1996

1996 Annual Reports and Resolutions

American Dental Association

ADA American Dental Association
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1996

Annual Reports and Resolutions

137th Annual Session

Orlando, Florida

September 28 - October 2, 1996

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Special Note

Copies of the 1996 *Annual Reports and Resolutions* have been mailed to both delegates and alternate delegates. Please bring your copy to the meetings of the House of Delegates.

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Notes

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Gary Rainwater, *president-elect*
Stuart B. Fountain, *first vice president*
Robert L. Bartheld, *second vice president*
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Notes

Reports of Councils and Commissions

Divisions of Communications, Conference and Meeting Services, and Membership and Dental Society Services

Council on ADA Sessions and International Programs

Council on Communications

Council on Membership

Notes

Council on ADA Sessions and International Programs

Metro, Patrick S., Ohio, 1996, chairman
Bilionis, Angelo L., Massachusetts, 1996
Cohlmia, Raymond A., Oklahoma, 1996, *ex officio**
Dickinson, Terry D., Texas, 1998
Erickson, Jerome A., Minnesota, 1998
Hagman, Gerrit C., Georgia, 1999
Kell, Kathryn A., Iowa, 1999
Kirk, Ann B., Massachusetts, 1998
Kondis, Stephen L., Pennsylvania, 1999
Lee, John G., Florida, 1996, *ex officio*
Leone, Edward, Jr., Colorado, 1996
Provenzale, Donald J., Sr., Illinois, 1997
Singer, Alan H., District of Columbia, 1997, *ex officio*
Yates, Morris C., Kentucky, 1997
Jeske, Edward T., director
Dujon, Dorsay, manager
Cherrett, Helen McK., manager
Johnson, Patricia, manager

Meetings: The Council met February 3-5, 1996 in Orlando at the Omni Rosen Hotel and May 11-13, 1996 at the Headquarters Building in Chicago.

Activities: During 1995-96, the Council on ADA Sessions and International Programs continued serving as the program coordinating body for the annual session, as well as acting as the committee to formulate and recommend policies related to the Association's role in international programs and serving as its liaison to the world dental community. At its February meeting in Orlando, the Council primarily discussed details for the 1996 ADA/FDI World Dental Congress and initial plans for the 1997 annual session in Washington, D.C. The Council also considered its international programs. Dr. William Ten Pas, ADA president; Dr. John Zapp, ADA executive director; Dr. Heinz Erni, FDI World Dental Federation president; and Dr. Per Ake Zillen, FDI executive director, also attended portions of this meeting. At its May meeting, the Council finalized plans for the 1996 Congress, continued further planning for 1997 and considered the international matters that are its responsibility. Dr. Ronald M. Chaput, First District trustee and the Board of Trustees' liaison to the Council, also attended these Council meetings.

The Strategic Plan of the American Dental Association:

Objective 2: Association Program and Financial Plan, and Objective 3: Membership Recruitment and Retention. The Association's annual session provides the highest caliber in continuing education to the membership and is therefore a valuable membership benefit while at the same time generating significant nondues revenues for the Association.

Objective 4: Access to Dental Care. The Council's ADA/HVO Dentistry Overseas Program improves access to dental care in developing countries and areas in crises that have little or no access.

Objective 6: Professional Image. By showing the international dental community that the American Dental Association is made up of ethical and compassionate dentists not bound by geographic barriers, the Council's ADA/HVO Dentistry Overseas Program also supports Objective 6.

Through membership and participation in the activities of the National Council for International Health (NCIH), the Association ensures that dentistry has a role in the international health care endeavors of the organization; therefore, the NCIH activities also support Objective 6.

136th Annual Session, Las Vegas, October 7-11, 1995

The site of the 1995 annual scientific session was the Las Vegas Convention Center. This facility housed most of the scientific program as well as the technical exhibition. Certain scientific courses were presented at the Las Vegas Hilton Hotel to provide additional program opportunities. Total registration was 55,435, including 16,918 dentists, 1,366 of whom were internationals. This was a record attendance for the annual session. The largest number of technical exhibit booths ever sold (1,436) made the exhibition the largest dental exhibit in the United States. Both the exhibits and the scientific programs were very well attended during the four-day meeting.

Scientific Program: In 1995, 111 courses on a wide selection of dental topics were offered in Las Vegas during the annual session. There was record attendance at the courses, with standing room only at most of the courses. Four courses were videotaped, and most of the other courses were audiotaped.

* Standing Committee on the New Dentist member without the power to vote.

These tapes were available for purchase at the meeting and afterwards.

A full schedule of registered clinics, lectures and participation workshops was offered during the annual session in Las Vegas. In addition to the open attendance courses, 11 participation workshops and 17 registered clinics were offered. The registered clinics covered a variety of topics, including bonding, endodontics, aesthetics, prosthodontics, periodontics, restorative dentistry, financial investments and practice management. Attendance at the clinics was 6,000. Participation workshop topics included endodontics, periodontal surgery, electrosurgery, bonding, composites, CPR, photography, temporization, overdentures and computers. Workshops had more than 550 participants. General interest topics included food, landscaping, gaming, collecting antiques, adolescence, retirement, financial planning, team building and a play.

Table Clinics: Over 100 table clinics on a variety of topics were presented on the Saturday and Sunday during the meeting. These presentations were also well-received. The winner of the 1995 National Outstanding Dentist Table Clinic Competition was Dr. Charles R. Holt, representing the Fort Worth (TX) District Dental Society. The title of his presentation was "A Simplified Splint Technique for Internal Derangement."

Post-Session Seminars: Post-session seminars were held at the Grand Wailea Resort, Maui, HI with two speakers each presenting two programs. Dr. Arun Nayyar and Dr. Roger Levin presented these programs. Dr. Nayyar's programs, "The Dynamics of an Exceptional Fixed Restorative Dental Practice" and "Enhancing Clinical Efficiency in a Fixed Restorative Practice," had attendance of 27 and 23 respectively. Dr. Levin's courses, "Turning Your Practice into a Profitable Business" and "Patient Satisfaction: The Key to Practice Growth," had attendance of 48 and 42 respectively.

ADA/Dentsply Student Clinician Program: The student program, which celebrated its 37th anniversary at the 1995 annual session, is conducted annually by the Council on ADA Sessions and International Programs and is financially supported by Dentsply International, Inc., York, PA.

Outstanding student clinicians representing 53 accredited dental schools in the United States and Puerto Rico presented table clinics on Monday afternoon at the Las Vegas Convention Center. On Tuesday morning the winning students presented their clinics.

Winning students in Category I, Clinical Application and Technique, were: Lisa S. Jacob, University of Texas Dental Branch at Houston, first place; Kelly K. Pfeifer, University of Texas Health Science Center, San Antonio, second place; and Scott P. Irwin, University of Missouri, Kansas City, third place.

Winning students in Category II, Basic Science and Research, were: Rada Sumareva, New York University Dental School, first place; Carrie L. Kiefer, University of North Carolina at Chapel Hill, second place; and Russell McCabe, Indiana University School of Dentistry, third place.

The first place winners in each category were awarded a travel prize to present their winning table clinics at the Chicago Dental Society Midwinter Meeting. Second and third prize winners in each category received awards of $500 and $250, respectively.

Judges for Category I were: Dr. John Olmsted, Greensboro, NC, chairman; Dr. Shirley Austin, Dearborn, MI; Dr. Cordell Fisher, Irvine, CA; Dr. Brenda Harman, Novato, CA; Dr. Arthur Hunger, York, PA; Dr. Keith Krell, Des Moines, IA; Dr. Dan Middaugh, Seattle, WA; and Dr. Jack Penhall, Jeannette, PA.

Judges for Category II were: Dr. Richard Tatum, Columbia, MD, chairman; Dr. Stephen Abel, New York, NY; Dr. Robert Augsburger, Tulsa, OK; Dr. Patricia Blanton, Dallas, TX; Dr. Carmen Yolanda Bonta, Piscataway, NJ; Dr. Thomas Emmering, Wheaton, IL; Dr. Peter Guevara, Pittsburgh, PA; Dr. Mirdza E. Neiders, Buffalo, NY; Dr. Rahele Rezai, Washington, DC; Dr. Roger Stambaugh, Santa Monica, CA; Dr. Thomas Van Dyke, Boston, MA; and Dr. Joel White, Half Moon Bay, CA.

137th Annual Session in Orlando, Florida, September 28-October 2, 1996

Orlando, Florida is the site of the Association's 137th Annual Session which is being held jointly with the 84th annual meeting of the FDI World Dental Federation as the 1996 ADA/FDI World Dental Congress. This meeting is the second time the annual session has taken place in Orlando and the first time since 1988 that the ADA has met with the FDI. The Orange County Convention Center is the location for the technical exhibits, table clinics and all of the scientific program, as well as other activities related to the scientific session. The Center also is the site of the ADA House of Delegates, Reference Committees and related offices, as well as the FDI General Assembly and its offices and business meetings.

Scientific Program: The scientific program offers courses on a wide range of topics, including aesthetics, bonding, endodontics, restorative dentistry, periodontics, dental materials, infection control, crown and bridge, team building and practice management. In addition to numerous general interest programs, Captain James Lovell is the Celebrity Speaker.

Table Clinics: Since this is a joint meeting of the ADA and FDI, the FDI Unilever Table Clinician Competition will be held instead of the National Outstanding Dentist Table Clinic Competition. Application and selection of clinicians were processed by the FDI London office. In addition to the table clinics, there will be free communications and poster demonstrations.

Post-Congress Seminars: Two post-Congress seminars will be offered. On Amelia Island, Florida, Dr. John Kois will be presenting a two-day seminar on "Structurally Compromised Teeth: Pins, Posts or Bonding?" Ms. Anita Jupp will be presenting a two-day seminar entitled "Leadership is an Integral Part of the Dental Practice," which will be presented in Aruba.

ADA/Dentsply Student Clinician Program: This year's student clinician program will mark its 38th anniversary at the

ADA annual session. Each accredited dental school has been invited to participate in this student table clinic competition. The winners of the Dentsply competitions in Canada, Japan, Scandinavia and the United Kingdom will also have their clinics available for viewing.

International Activities

Certificate of Recognition for Volunteer Service in a Foreign Country: At its May meeting, the Council awarded 99 dentists in 25 states the Certificate of Recognition for Volunteer Service in a Foreign Country. Since the program was initiated in 1975, 1,773 Certificates have been awarded to individuals in 48 states and the District of Columbia. This year, two articles about the program appeared in the *ADA News* and a mailing was sent to constituent and component dental societies, the federal dental services, volunteer organizations and the deans of dental schools, which resulted in the processing of 121 applications. The discrepancy in the number of applications presented and the number of certificates actually awarded is generally because of lack of adequate documentation for some applications.

This program continues to be well-received throughout the profession, as evidenced by the number of nominations, publicity in dental journals and presentation of the Certificates at dental society meetings. It also assists the Council in locating the increasing number of volunteer programs that use dental personnel.

International Subscription Program: Since this program was revised in 1982, subscriptions have been sent to dental school libraries and dental organizations in Africa, Asia, Europe and the Middle East, as well as Central America and South America. This year the Council registered 81 subscriptions to *Dental Abstracts* and one other U.S. dental periodical of choice. All new recipients are now encouraged to select from Association publications for both their periodicals. The provision of current professional journals to dental school libraries in developing countries proves to be one of the most effective and least costly ways of helping to raise standards and improve the dental health of these countries' citizens. The many letters of appreciation received by the Council attest to the valuable contributions the journals make to dental educational programs.

National Council for International Health (NCIH): The NCIH was established in 1971 as a private, nonprofit membership organization dedicated to improving health worldwide. NCIH serves the international community by promoting dialogue on health and development issues, fostering communication between public and private sectors, and creating links between public health professionals in the United States and abroad. This organization, of which the ADA is a founding member, is flourishing and serves a broad segment of the international health community. The Association participates actively through its representative, Dr. Patrick Metro, who is a member of the Governing Board and was elected to the NCIH Executive Committee in January 1995. He attends all the Governing Board meetings and the annual conference, which is held in Washington, D.C. This conference is the largest gathering of its kind in the United States. Attracting health and development professionals from around the world, it serves as an interactive forum for the international health community to share common experiences and to review and present strategies to improve health programs and policies. This year, the theme of the 23rd Annual International Health Conference was "Global Health: Future Risks, Present Needs." As part of this conference the Council held a dental caucus which provided an opportunity to share and collect information on the dental activities of voluntary health service organizations.

Dentistry Overseas: In 1989 the Board of Trustees adopted a proposal (*Trans.*1989:471) that established an ADA Voluntary Service Program, under the auspices of Health Volunteers Overseas (HVO). The program is managed by a special steering committee, composed of six consultants. Dr. Hugh Cooper, Dr. J. Michael Delaney, Dr. Valerie A. Robison, Dr. Francis G. Serio, Dr. Eric E. Spohn and Dr. Rosalie A. Warpeha were appointed to serve on the committee for terms ending with the 1996 annual session.

The committee met on January 17 in Washington, D.C. and on May 15 in Chicago. Dr. Robison was appointed chair for 1996. At these meetings, the committee reviewed current programs in Santarém, Brazil; Vellore, India; Jamaica; St. Lucia; and Ho Chi Minh City, Vietnam. The committee also decided to reinitiate the program in Grenada. A site visit to Bolivia indicates that this will be the location of the next program. The committee also reviewed possibilities for programs in Belarus, Bhutan, Cambodia, China and Fiji. As of April 1, 1996 there were 150 members in the Dentistry Overseas Division of HVO. During 1995, there were 37 dental volunteers: six in Brazil; three in Guyana; one in India; one in Jamaica; nine in St. Lucia; three in Russia; and 14 in Vietnam.

In January 1995, through the efforts of Dr. Cooper, an Oral Health Survey of School Children was conducted in Guyana which involved the cooperation of the Pan American Health Organization, the Government of the Republic of Guyana and Health Volunteers Overseas/Dentistry Overseas (ADA). The findings were published in March 1996. Through the assistance of Dentistry Overseas, Guyana held its First National Dental Convention on April 12-14, 1996 in Georgetown. The President of Guyana, Dr. Cheddi Jagan (a Northwestern University dental graduate), presided over the Opening Ceremony and was presented with the results of the survey. Dr. Jagan also gave an audience to the Steering Committee and talked about how HVO could focus on the continuing education of both dentists and dental nurses. Volunteers should be able to start rotations in Guyana by January 1997.

The HVO annual orientation workshop for prospective volunteers was held in Tucson, AZ on March 21-24. The three-and-a-half-day workshop was geared to health care professionals who are considering volunteering. Topics included: HVO's philosophy and program; cross-cultural communication; clinical experiences in developing nations; cost constraints and appropriate technology; cultural, ethical and political controversies in the volunteer clinician's role; and specialty sessions in dentistry. Dr. Robison served as the facilitator. Additionally, as part of the annual session scientific program, the ADA/HVO program was updated for the members and an educational forum entitled "International Dentistry: Partners Working Together" was presented. For

the first time two representatives of recipient countries, one from the dental school in Ho Chi Minh City and one from the government of Grenada, presented their views of the programs from professional, personal and national perspectives. Program chairpersons and volunteers were available for questions after the formal presentation.

Recommendations for Policy Rescissions: At its May meeting, the Council reviewed those policies which relate to areas of its functioning. As a result, the Council recommended rescinding policies pertaining to advertising and product promotion on closed circuit television programs; United States dentists traveling abroad; and international relations committees. The Council believes these policies do not reflect the manner in which its business is currently conducted.

1. Resolved, that the following resolutions be rescinded:

Resolution 33-1962-H (*Trans.*1962:211, 274), Statement of Policy on Advertising and Product Mention on Closed Circuit Television Programs;

Resolution 16-1964-H (*Trans.*1964:267), International Relations Committees; and

Resolution 20-1968-H (*Trans.*1968:107, 291), U.S. Dentists Traveling Abroad.

Acknowledgments: The Council wishes to voice its sincere appreciation to Dr. John Lee, general chairman of the 1996 Committee on Local Arrangements, who leaves the Council after this year's annual session. The Council also wishes to thank those who so competently assisted Dr. Lee: Dr. Roger Nofsinger, committee vice chairman; Dr. Hutson McCorkle and Dr. Neil Powell, chairmen, Program Coordinating Committee; Dr. Carter Greear and Mrs. Beverly Greear, co-chairpersons, Hospitality Committee; and Dr. Richard Altman and Dr. Robert Pellarin, chairmen, Committee on Registration and Special Services.

The Council wishes to express special gratitude to Dr. Hugh Cooper of Ann Arbor, MI, who completes his term at the end of 1996, after seven years of service on the ADA/HVO Steering Committee, including two years as chairman (1990, 1991). Dr. Cooper initiated the concept of the ADA international volunteer service program and has worked diligently to ensure that whenever Dentistry Overseas takes on an assignment, it does so with dedication and adheres to the Association's professional and ethical standards. Dr. Cooper's superb efforts in this area are a reflection of his personal commitment to the highest standards of humanitarianism.

The Council also wishes to acknowledge the contributions of its members who will be leaving the Council after the 1996 annual session: Dr. Patrick S. Metro, 1996 Council chairman and general chairman of the 1996 Congress; Dr. Angelo L. Bilionis; and Dr. Edward Leone, Jr.

Summary of Resolutions

1. Resolved, that the following resolutions be rescinded:

Resolution 33-1962-H (*Trans.*1962:211, 274), Statement of Policy on Advertising and Product Mention on Closed Circuit Television Programs;

Resolution 16-1964-H (*Trans.*1964:267), International Relations Committees; and

Resolution 20-1968-H (*Trans.*1968:107, 291), U.S. Dentists Traveling Abroad.

Council on Communications

Ward, Elizabeth A., Missouri, 1997, chairman
Barna, Julie Ann, Pennsylvania, 1996
Bowers, Donald F., Ohio, 1998
Niekrash, Christine E., Connecticut, 1996
Oberbreckling, Paul J., Wisconsin, 1999
Perle, Charles H., New Jersey, 1999
Pitts, Dan O., Alaska, 1998
Smith, Richard A., Georgia, 1998
Mickel, Clayton B., director
O'Donnell, Kathleen, manager

Organization: Under the leadership of the Council on Communication's Chairman, members volunteered to serve on small work groups to assist with the implementation of directives and requests of the Council, and to act as advisers on projects or issues. Each member also served as a contact with one of the eight trustee districts not currently represented on the Council. Dr. Victor J. Barry, Eleventh District trustee, served as the Board of Trustees' liaison to the Council. The Council received regular detailed reports from its Director on the status of communications projects, issues and concerns, and was advised and consulted via fax and electronic mail, when necessary. By early 1996, all Council members had fulfilled their mutual agreement to go "on line" to facilitate regular communication with one another via e-mail, and as an expression of their commitment to *ADA ONLINE*.

The Strategic Plan of the American Dental Association: The Council received the 1995 Strategic Plan prior to its January meeting. In addition, a brief presentation on the Strategic Plan was made at the meeting by the Director of the Office of Quality and Strategic Planning, at the Council Chairman's request, to emphasize the central role of the Association's Strategic Plan in the Council's deliberations.

Objective 6: Professional Image. This is the objective that most directly applies to the Council. Several of the Council's activities support Objective 6, including the Association's national education, promotion and media campaigns, such as National Children's Dental Health Month, the ADA Seal of Acceptance campaign and the ADA National Spokespersons Program, as well as ADA Spokesperson Training Seminars and media materials for dental societies. The professional image has been greatly enhanced by the debut of *ADA ONLINE*, the Association's site on the Internet's World Wide Web. *ADA ONLINE* reaches an international audience 24 hours a day, 365 days a year.

Objective 1: Legislative and Regulatory Advocacy. Communications activity for the Grassroots network is supported by the Council and helps the Association to meet Objective 1. The new Washington Communications office established in 1995 has increased the Council's role in expanding communications support to the Association's activities in legislation, regulation and policy initiatives.

Objective 3: Membership Recruitment and Retention. As directed by the Council on Communications and supported by the Council on Membership, a new Association membership recruitment and retention video has been developed to replace the print annual report for members. With the Council's support, a new dental careers subsite, Association membership information and the Tripartite Membership Application were added to *ADA ONLINE*, the Association's site on the Internet's World Wide Web.

Objective 4: Access to Dental Care. One of the Council's primary activities is to increase communications with both the profession and the public on marketplace and managed care issues. In addition, the Council supports Objective 4 through national promotions targeted for specific audiences on certain oral health topics, such as tobacco cessation and women's oral health.

Objective 12: Constituent and Component Societies. The Council's leadership in and support for electronic communications and programs such as the ADA Spokesperson Training Seminars help strengthen the partnership between the Association and its constituent and component societies.

Meetings: The Council met in the Headquarters Building in Chicago on January 26-27, 1996 and is scheduled to meet again on June 7-8, 1996.

Personnel: At the January 1996 meeting, the Council selected Dr. Julie Ann Barna as vice chairman for 1996.

Activities: Council representatives attended the House of Delegates at the 1995 ADA annual session and the Public Affairs Conference on March 17-19, 1996 in Washington, D.C. Representatives will also attend the National Conference on the Young Dentist on July 25-27, 1996 in Cleveland, Ohio and the National Strategic Planning Conference for the Prevention and Control of Oral and Pharyngeal Cancer on August 7-9 at Association Headquarters.

***ADA ONLINE*:** *ADA ONLINE* was launched on June 30, 1995. Since then, the Association's World Wide Web site has grown and developed at a rapid pace, supporting many of the objectives of the Strategic Plan. This evolving electronic communications system continues to branch out, creating an extensive network of support and access for the Association's members, internal agencies, dental societies and the public.

ADA ONLINE, which has won two awards for excellence, offers access to information under four categories: News; Practice and Profession; Products and Services; and

Consumer Information. Major content additions are made on a regular basis.

The Council supported *ADA ONLINE*'s live, free, hands-on promotion to dentists and others at major dental meetings throughout the country.

The Council recommended to the Association's Board of Trustees that developments in the information technology upgrade and in computer and communications technology be closely followed so online differentiation between members and nonmembers can occur when feasible.

Marketplace and Managed Care Issues: The Council assumed a key role in the implementation of the requirements in Resolution 122H-1994 (*Trans.*1994:648), particularly as they concerned educational and informational materials and activities for dentists and the public on the marketplace and managed care issues.

At its January meeting, the Council considered a report on a 1,000+ telephone survey conducted to assess consumers' knowledge base, attitudes and experience with dental managed care programs. Based on the survey results, a "statement stuffer" will be developed for consumers. The content will likely focus on the need for patients to speak to their dentists before they change dental coverage, plans or dentists. At the Council's request, the Association's Managed Care Resource Packet and a camera-ready advertisement on managed care materials were sent to editors of dental journals.

Also, at the Council's direction, Division of Communications staff worked closely with Division of Dental Practice staff on managed care research. At its June meeting, the Council will receive a report on the results of eight consumer focus groups. Findings from three additional focus groups of decision makers and benefits managers from small, midsize and large companies on managed care and direct reimbursement issues are also expected at the June meeting.

Additional Council activities on marketplace and managed care issues are addressed in the final section of this report, Response to Assignments from the 1995 House of Delegates.

National Spokespersons: At its January meeting, the Council was provided written criteria for ADA national spokespersons, and members were invited to submit potential candidates for consideration. The Council and Communications staff continue to screen and evaluate consumer adviser spokesperson candidates. Consumer advisers received media training at a spokesperson seminar in May. For the first time, ten of the Association's expert spokespersons in specific areas, such as infection control, amalgam and dental unit waterlines, attended a new spokesperson training session for expert advisers last fall.

Under new procedures instituted in 1995, the Council Chairman and Vice Chairman gave final review and approval to all Association news releases before distribution to the media.

The public image of dentistry and the Association was further strengthened with numerous positive media placements, including three major stories featuring ADA spokespersons on the NBC-TV "Today Show" and the ABC-TV program "20/20," reaching combined audiences of 45 million viewers.

Association productions garnered more than 15 major awards from national competitions. "Dudley and Dee Dee in Nutrition Land" was shown in Los Angeles movie theaters in October to qualify for the Academy Awards. The film print is now part of the Motion Picture Arts and Sciences Academy's permanent collection.

Advocacy Communications: At its January meeting, the Council reviewed reports from the Washington Communications Director on direct communications support to ADPAC on an intensive political education campaign for the Grassroots Action Teams, as well as editorial services for the Division of Government Affairs.

The Council sent its Vice Chairman to the Public Affairs Conference in Washington, D.C. in March.

Training in legislative testimony presentation, public speaking and media interviews on topics such as "Dentistry: Health Care That Works," dental care delivery systems and supervision of dental hygienists was provided in Spokesperson Training Seminars for constituent and component dental societies. The seminar program was revamped for 1996 to make it even more accessible to dental societies, with new audiovisual presentations and an increased emphasis on marketplace, policy and critical issues message development.

Membership Recruitment and Retention Video: At the recommendation of the Council and supported by the Council on Membership, a new Association membership recruitment and retention video was developed to replace the print annual report to members. An interdivisional work group worked with the two Councils to approve the content outline, the final script and the rough cut, which was also screened for the Board of Trustees. The video will be mailed to dental societies, dental specialty organizations and dental schools, with business reply cards enclosed. The reply cards will be returned to the Division of Membership and Dental Society Services to monitor usage.

Oral Health Education and Promotion

Seal of Acceptance Promotion: The Council reviewed a report in January on the successful ADA Seal Promotion launched at the 1995 annual session. A press conference, "Dental Newsline" radio reports, a video news release (VNR) and satellite media tour released new survey information indicating the Seal's impact on the more than $3.3 billion oral health care market. A copy of the press kit, VNR and a supply of new Seal brochures were provided to Council members. An issue of the *ADA News* included a special insert on the Seal that dentists can reproduce and give to their patients. The VNR and brochures were also sent to dental school deans with a letter encouraging inclusion of the importance of the Seal in classes.

National Children's Dental Health Month: At its January meeting, the Council received a report on preparations for the 47th annual National Children's Dental Health Month (NCDHM) in February, 1996. Dudley the Dinosaur returned to help everyone "Discover the Clues to a Healthy Smile." The Association's new public service announcement (PSA), "Dudley and Gramps Brush and Floss," was released to major television networks and more than 600 stations across the country. A Hispanic version of the PSA also was distributed

to the two major Spanish networks and 50 Spanish-speaking stations nationwide.

Also, the Association's first interactive video news release, directing viewers to access *ADA ONLINE* for additional information, was released in conjunction with NCDHM. The two-minute VNR, featuring world-renowned Harvard pediatrician Dr. T. Berry Brazelton and an ADA spokesperson, emphasized the importance of early dental care. The Association's "Dental Newsline" weekly radio series dedicated all February broadcasts to NCDHM topics. Almost one year after the reformatted "Dental Newsline" began broadcasting, the annual audience increased by one million listeners to 73 million.

Child Abuse Prevention Resources Kit: Three members of the Council volunteered to assist staff in the development of a Child Abuse Prevention Resources Kit for distribution to dental societies. This project was at the request of, and in conjunction with, the Council on Access, Prevention and Interprofessional Relations.

Response to Assignments from the 1995 House of Delegates

"Special Athletes, Special Smiles": Resolution 87H-1995 (*Trans.*1995:614) directed that the appropriate agencies of the Association study and report to the Board of Trustees ways in which the ADA could become more directly involved and/or responsible for a dental program concerned with the Special Olympics. This resolution was assigned to the Divisions of Communications and Dental Practice. This report will be given to the Board of Trustees at its July meeting, with recommendations based on: input from the Council on Access, Prevention and Interprofessional Relations and its staff; information on current activities of the "Special Athletes, Special Smiles" program; and input from the Council on Communications.

National Advertising Campaign: Resolution 112-1995 (*Trans.*1995:604) directed the Council to report to the 1996 House its recommendations on a national advertising campaign. A written report and background materials were provided to the Council at its January meeting, and staff made a detailed presentation on the implications of a national advertising campaign. After extensive analysis and discussion of this resolution, the Council directed staff to develop a model for a multiyear national advertising campaign on marketplace issues that is focused primarily on dental plan purchasers. The model will be considered at the Council's June meeting.

Direct Reimbursement: The Council assumed a key role in the implementation of the requirements of Resolution 129H-1995 (*Trans.*1995:621), particularly as they concerned a national marketing campaign to promote direct reimbursement. At its January meeting, the Council considered a report on the status of the implementation of Resolution 129H. The Council Chairman served on the special task force assigned to implement Resolution 129H, which met in March and developed a proposed $400,000 advertising budget for consideration by the Board of Trustees. The requested funding and selection of Foote, Cone & Belding (FCB) Direct as the marketing firm to implement a national advertising campaign was unanimously approved by the Board of Trustees at its April meeting. FCB will present the campaign to the Council at its June meeting.

Resolutions: This report is informational in nature and no resolutions are presented.

Council on Membership

Kenneally, Joseph R., Maine, 1996, chairman
Lee, William E., Kentucky, 1996, vice chairman
Adams, Anne C., Virginia, 1999
Aronson, I. Leon, Georgia, 1998
Brodoski, Richard V., Michigan, 1999
Goodman, Susan B., Maryland, 1996, *ex officio**
Howard, Lisa Peter, Minnesota, 1996
Kenworthy, Joseph M., III, Texas, 1997
Laing, Kevin M., Ohio, 1998
McGuire, Eugene J., Pennsylvania, 1996
Morgenstern, Thomas F., New Jersey, 1999
Reyes, Reneida, New York, 1997
Sakuma, Karen D., Washington, 1998
Schinnerer, Donald M., California, 1999
Tapia-Quiller, Margaret Ann, Colorado, 1997
Torchia, James S., Oklahoma, 1998
Tuneberg, Perry K., Illinois, 1997
Jarr, Paul W., director
Scully, Laura C., manager

Meetings: The Council met at the Headquarters Building on February 2-4 and June 21-23, 1996. Dr. Frank A. Maggio, Eighth District trustee, served as the Board of Trustees liaison to the Council. The Chair appointed three subcommittees of the Council to focus on major areas of activity: Tripartite Membership Issues, Target Marketing Issues and Member Benefits/Communication Issues. The subcommittees met on February 2 and June 21, 1996.

Personnel: At its February 1996 meeting, the Council elected Dr. William E. Lee as vice chairman for 1995-96. At the close of the 1996 annual session, the terms of four valued members of the Council will end: Dr. Joseph R. Kenneally, who served as chairman of the Council for 1995-96; Dr. Lisa Peter Howard, who served as vice chairman for 1992-93; Dr. William E. Lee, who served as vice chairman for 1995-96; and Dr. Eugene J. McGuire, member, 1993-96. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure.

Response to Assignments from the 1994 and 1995 Houses of Delegates:

Expansion of an Electronic Dues Payment Program. Resolution 86H-1994 (*Trans.*1994:617) extended the California Dental Association (CDA) Electronic Dues Payment Program pilot until 1996. The Electronic Dues Payment Program pilot allowed California Dental Association members to pay their dues in equal monthly installments beginning in November, with full payment of the current dues amount to be fully paid by June. The CDA was to report its findings from the two-year pilot study to the appropriate agency within the Association by June 1996 for evaluation and report to the 1996 House of Delegates. Any Council recommendations will be reported in a supplemental report to the 1996 House of Delegates.

Transfer Nonrenews. Resolution 36H-1995 (*Trans.*1995: 605) directed that constituent and component societies be encouraged to address the issue of nonrenewing members who transfer into their jurisdictions. The Council Chairman communicated Resolution 36H-1995 to the Council's State Membership Chair Network in January. At its February meeting, the Council directed staff to continue to develop and implement strategies that address the problem of transfer nonrenews. Strategies include sending component societies lists of transfer nonrenews, on a biannual basis, with suggestions on how to contact and follow up to successfully encourage these dentists to renew their membership. Opportunities to work with ADAPCO to place a change-of-address card in *ADA News* have been explored.

Promoting the Value of Tripartite Dentistry and Utilization of Tripartite Resources. Resolution 37H-1995 (*Trans.*1995: 606) directed that constituent and component dental societies be encouraged to identify new mechanisms to promote the value of tripartite membership. Resolution 38H-1995 (*Trans.*1995:604) directed that constituent and component dental societies be encouraged to utilize tripartite resources in their respective membership communications to demonstrate the full array of available tripartite benefits. The Council Chairman communicated Resolutions 37H-1995 and 38H-1995 to the Council's State Membership Chair Network in January and April. The communications underscored the importance of establishing close ties between membership committees and those committees designated to address new dentist issues, as well as sharing state membership committee activities with appropriate Association Council representatives.

* Standing Committee on the New Dentist member without the power to vote.

Review of Association Dues Structure. Resolution 39H-1995 (*Trans.*1995:604) directed that the Association conduct a comprehensive review of the effectiveness of the current dues structure, seeking input from all communities of interest, for a report including appropriate recommendations and impact analyses to the 1996 House of Delegates. At its February meeting, the Council recommended that an appropriate sample of member dentists also be surveyed for their opinions and perceptions on ADA dues and membership policies. The Council further recommended that constituent society presidents from 1993 and 1995 be added to the current survey sample and that related groups included in the sample be asked to consider their respective membership chairs as the potential respondent on behalf of the organization. The Council will receive a report of the Dues Structure Study at its June meeting. Any further action will be reported in a supplemental report to the 1996 House of Delegates.

Diversity in Association Print Materials. Resolution 40H-1995 (*Trans.*1995:606) reinforced the Association's commitment to promoting an inclusive environment that values membership diversity and directed that the Association reflect this diversity in membership marketing and consumer-related materials. The Council Chairman communicated Resolution 40H-1995 to the Council's State Membership Chair Network in January. In December 1995, the Council also sent an internal communication regarding Resolution 40H-1995 to Association agencies.

Development of Financial Planning Publication for Dental Students. Resolution 108-1995 (*Trans.*1995:644) was assigned to the Council on Membership with assistance from the Council on Dental Practice. This resolution sought the development of a financial planning resource targeted to first-year dental students which would help them manage the costs of their dental education. The Council discussed this resolution at its February 1996 meeting and directed that a prototype brochure be developed in collaboration with the Council on Dental Practice. The Council will review a draft of the brochure and a plan for distribution at its June meeting and report to the 1996 House of Delegates.

Definition of the Word "Elect" as Found in the Bylaws to Mean "Select" by Vote. Resolution 138-1995 (*Trans.*1995: 607) was referred to the Council for study with input from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA). The resolution requests that the House of Delegates define the word "elect" as found in Association *Bylaws* to mean "select" by vote. CEBJA will provide its recommendations to the Council for its June meeting. Any recommendations will be reported in a supplemental report to the 1996 House of Delegates.

The Strategic Plan of the American Dental Association: The Council on Membership supports the development of the Association's recruitment and retention activities based on strategies identified in the *Recruitment and Retention Business Plan.* Since 1986, more than 100 strategies and tactics have been implemented, with new strategies and tactics continually being developed, added or deleted based on prior successes or failures.

Membership recruitment and retention for the Association has always been a tripartite activity. Objective 3 of the Association's Strategic Plan reflects the critical need to work cooperatively with constituent and component dental societies to develop and implement cost-effective recruitment and retention programs. Since its inception in 1993, the Council has shifted the focus of the *Recruitment and Retention Business Plan* from lead-generating campaigns to target market development based on central themes that promote the value of membership. Some of these activities include the *Membership Benefit Briefs* newsletter, which highlights tripartite recruitment and retention techniques for leaders and volunteers; the Membership Resource Center Booth at major ADA and constituent society meetings in 1996; and the 1996 *Benefits Communication Plan*, a comprehensive plan that provides consistent and reliable resources for state and local recruitment and retention programs and enhances the recruitment and retention skills of dental society leadership and staff. Strategies also include benefits promotion and the development of a variety of recruitment and retention resources for use by constituent and component societies, particularly those that encourage recruitment and retention through personal contact: leader-to-volunteer, dentist-to-dentist. Ongoing activities include the Field Service Program, now in its fifth year of operation, and the Committee on the New Dentist's Transition Program for senior dental students.

National Market Share: End-of-year national membership market share statistics indicate that the total number of American Dental Association members has increased by 1,397 to 141,412. The national market share of active licensed dentists is 73.4%, compared with a 73.5% market share in 1994, only a 0.1% decrease. All indicators suggest that market share erosion has been virtually stopped after seven years of decline.

Table 1 (page 22) compares 1995 target markets with 1994 data for the groups to which the ADA targets membership recruitment and retention efforts. There were increases in most of the target groups, with the largest increase in the new dentist target market (an increase of 2.3% to 67.5%). Other notable increases were in the women dentist market share (an increase of 1.3% to 65.4%) and the graduate student market share (an increase of 1.7% to 80.7%).

There were decreases in market share for the full-time faculty (-2.0%) and the specialist (-0.5%) target markets, with the largest decrease in the federal dental service (FDS) market share (-2.8%).

Overall Market Trends: In 1995, the market increased to 198,984. Market share is impacted by several factors called market indicators: the total number of members; the number of new members; the total nonrenews; and those nonrenews who were active members. These four key market indicators continued to improve in 1995 and market share erosion has been greatly decreased. Table 2 (page 22) shows improvement in all four indicators over 1994.

New Members: In 1995, there was an increase of 1,361 new members from 1994. Of the 1,361 new members, 815 graduated less than ten years ago. As in 1994, there was an increase (317) in the number of new members who have been out of dental school for one to three years. This continued increase can be attributed to the emphasis on recruitment of recent graduates. The largest increase was in the number of new members who have been out of dental school more than

Table 1

TARGET MARKETS Active Licensed Market Share Year-end Comparison 1994-1995			
Target Group	**1994 Active Licensed Market Share**	**1995 Active Licensed Market Share**	**One Year Difference**
All U.S. Dentists	73.5%	73.4%	-0.1%
Young Dentists	67.3%	68.9%	+1.6%
Women	64.1%	65.4%	+1.3%
All Faculty	78.6%	77.0%	-1.6%
Full-time Faculty	71.6%	69.6%	-2.0%
General Practitioners	71.0%	71.1%	+0.1%
Specialists	83.9%	83.4%	-0.5%
Federal Dental Service (FDS)	64.6%	61.8%	-2.8%
Graduate Students	79.0%	80.7%	+1.7%
Foreign-Trained Dentists	56.5%	57.5%	+1.0%
All Minorities	59.8%	60.1%	+0.3%
New Dentists	65.2%	67.5%	+2.3%

Note: Target markets overlap and should not be added together.

Table 2

MARKET SHARE INDICATORS 1994-1995				
Year	**Total Membership**	**New Members**	**Total Nonrenews**	**Active Nonrenews**
1994	+611	+118	-482	-233
1995	+2,139	+1,361	-376	-114

Table 3

ACTIVE LICENSED NEW MEMBERS 1994-1995			
Years Since Graduation	**1994**	**1995**	**Change**
1-3	6,328	6,645	+317
4-6	1,018	1,357	+339
7-9	687	846	+159
10-12	512	605	+93
Over 12	1,079	1,532	+453
TOTAL	9,624	10,985	+1,361

Note: Includes only new members who are licensed U.S. dentists.

12 years. Table 3 (page 22) provides a breakdown of the number of new members by years since graduation from dental school.

Nonrenews: In 1995, retention improved 0.1%. Only 3.3% of active members did not renew, compared with 3.4% in 1994. In other words, the American Dental Association has a retention rate of 96.7%. There were 114 fewer active nonrenews in 1995 than in 1994, and the total number of nonrenews decreased by 376.

Of the 5,644 members who failed to renew in 1995, 204 (4%) were active life members. The percentage of nonrenews who were under age 40 decreased from 63% in 1994 to 32% in 1995.

Direct Members: The Department of Membership Information is responsible for retention of direct members by producing the billing statements for federal dental service dentists, graduate students, international dentists (U.S. dentists practicing abroad), affiliates (foreign dentists), associates (nondentists) and provisional members (recent graduates not yet licensed in their state). Total 1995 dues revenue generated from direct members was $1.4 million.

The overall market share for the federal dental services (FDS) continues to decline, with five of the six branches experiencing market share decreases. Over the past three years, the total FDS market share has dropped 5.5%; in 1993 the market share was 67.3%; in 1994 the FDS market share decreased 2.7% to 64.6%; and in 1995 the market share decreased 2.8% to 61.8%.

Graduate students' year-end 1995 membership market share was 80.7%, showing a 1.7% increase in market share over 1994. Additional mailings to this group and a decrease in market size contributed to the improvement in market share.

Field Service Program: The Field Service Program continues to play an important role in tripartite membership activities. The goal of the program is to provide "hands-on" assistance to selected dental societies to help increase membership and enhance tripartite communications. Since the inception of the program in 1991, 54 dental societies have participated in the program.

Another 12 dental societies were selected this year to participate in 1996 and 1997. These include: Detroit District Dental Society, Los Angeles Dental Society, Harbor Dental Society (CA), San Diego Dental Society (CA), San Fernando Valley Dental Society (CA), Passaic County Dental Society (NJ), Middlesex County Dental Society (NJ), Tennessee Dental Association, Kentucky Dental Association, Indiana Dental Association, Virginia Dental Association and Wisconsin Dental Association.

A review of the Field Service Program results for Phase IV (1994-95) showed that field sites equaled or outperformed national averages in several key indicators, including percent changes in the numbers of nonrenews, transfer nonrenews, active member nonrenew rates, market share averages and increase in total membership. Field sites also outperformed national market share averages in most target markets, including young dentists, faculty, general practitioners, specialists and foreign-trained dentists. Of particular note was the field sites' performance in the area of nonrenews. On average, field sites decreased active nonrenews by 20% and transfer nonrenews by 63.1%.

The Field Service Program remains one of the most highly valued membership services as evidenced by a 1995 Constituent and Component Survey conducted by the Department of Dental Society Services. Seventy-one percent of constituent societies and 56% of component societies responding to the survey rated the Field Service Program the membership support program they would be most likely to use. In addition, Field Service Program evaluations show that participants have consistently been very satisfied with the program. The Field Service Program continues to serve as an important laboratory for Association membership activities.

Many of the Association's diversity efforts have been launched as a direct result of Field Service activities, i.e., the Ten Steps for Addressing Membership Diversity (part of the Council on Membership's package library on Diversity Resources), including three diversity forums that have been conducted over the past year and a half during the Conference on Membership Recruitment and Retention (formerly the Field Service Program Conference).

Recruitment and Retention Resources: Increasing members' understanding of ADA benefits and providing dental society leadership and staff with the tools to recruit and retain members remained priorities of the Council in 1996. The Department of Membership Services produced a number of resources for membership recruitment and retention. Most of these resources, designed to convey the value of membership, are for use by constituent and component dental societies; others, such as the membership advertisements in ADA publications or the list of membership benefits provided through *ADA ONLINE* are targeted to the member or potential member.

A new ADA membership benefits brochure, *Membership Matters*, was developed for distribution to nonmember and member dentists. Copies were made available to constituent and component societies at no charge for use in their membership recruitment and retention activities. The benefits brochure was designed to be a companion piece to the new ADA membership video.

The ADA home page on the World Wide Web now includes information on the benefits of ADA membership to increase the exposure of membership information to both members and nonmembers. A tripartite membership application is also available on *ADA ONLINE*.

As part of a general recruitment effort, a special expanded circulation issue of *The Journal of the American Dental Association* (JADA) was mailed in January 1996. It included a cover-wrap for nonmembers underscoring the membership message and was sent to approximately 35,000 nonmembers. An extensive article on 1995 ADA accomplishments was also included, as was a membership advertisement.

The Department of Membership Services continues to distribute the *Membership Benefit Briefs* newsletter as a membership marketing resource for constituent and component societies. This bimonthly publication highlights and explains ADA benefits and provides a forum for dental societies to share successful recruitment and retention strategies.

The Department of Membership Services continues to offer two workshops for dental societies interested in recruitment and retention training for membership staff and volunteers: Ten Steps and 25 Tips for Recruitment and Retention Success, providing strategies developed through the Field

Service Program; and Membership Benefits Communication, translating the benefits of membership into tangible and compelling language for recruiting key target audiences. Seventeen workshops have been held since the last annual report.

The tripartite benefits brochure, *The Power of Organized Dentistry,* continues to be a popular resource to help dental societies convey the value of tripartite membership. This brochure, customized to specify the membership benefits of each unique ADA/constituent/component combination, was promoted primarily through the Field Service Program, workshops and conferences. In 1995-96, more than 75 customized membership benefits brochures were developed for component dental societies.

The Department of Membership Services was also responsible for coordinating tours of the ADA Headquarters Building. Staff have conducted over 100 tours for visitors in 1996. Visitors receiving tours have included dental students; constituent presidents-elect; members in Chicago for dental meetings or on vacation; dental spouses; and international guests. In addition, a tour of the building is included as part of every new employee's orientation. The response to the tour program by visitors has been very positive.

ADA Conference on Membership Recruitment and Retention: In an effort to further expand and strengthen tripartite membership activities, the Council conducted the third Conference on Membership Recruitment and Retention in November 1995 at ADA Headquarters. The purpose of the conference was to assist constituent and component dental society volunteer leaders and staff in their recruitment and retention activities and to share proven techniques to enhance membership.

The November conference attracted a record number of attendees, including 44 dentists and 42 staff representing 14 components and 26 states, Canada and Puerto Rico. In addition, representatives from seven related dental organizations were present. Dr. William S. Ten Pas gave the opening address and moderated a special diversity panel discussion, which included the president of the Hispanic Dental Association, the immediate past-president of the American Association of Women Dentists and the president-elect of the National Dental Association. Another conference is planned for November 1-2, 1996 at ADA Headquarters.

Student Marketing Plan: In accordance with Resolution 78H-1993 (*Trans.*1993:686), which directed the Association to develop action plans to increase recent graduate membership by effectively communicating the value of membership in organized dentistry to predoctoral students, the Council developed a comprehensive Student Marketing Plan directed toward dental students, recent graduates, new dentists, faculty and constituents and components.

The ultimate goal of the Student Marketing Plan is to increase ADA student market share to 100% and to establish a lifelong membership commitment to organized dentistry among students and recent graduates. To achieve this goal, the 1994-95 Plan was built upon five strategies:

1. increase direct communications with all predoctoral students to increase their awareness and understanding of ADA membership benefits;
2. coordinate membership marketing activities with American Student Dental Association (ASDA);
3. educate students to tripartite structure and how to join organized dentistry;
4. increase the ADA's understanding of the needs and interests of dental students at each stage of their education; and
5. explore strategies to extend membership to all dental students.

In 1996, the Council added a sixth strategy: to strengthen and position the Office of Student Affairs as the point of entry for students into the American Dental Association. The programs and activities included as part of the 1996 Plan were developed by the Council to support one or more of the approved strategies.

The Student Marketing Plan is a combination of direct mail, personal and tripartite contacts and reinforcement of membership value messages. Every dental student and recent graduate receives a variety of messages from the ADA which educate him or her to the services and value of membership, increase his or her awareness of organized dentistry and reinforce the importance of continuing membership throughout his or her career. Additionally, personal contacts from the ADA, tripartite dental societies and the Committee on the New Dentist make intangible benefits tangible and more understandable, convey to dental students that they are truly valued and engage students in dialogue. New activities in 1995-96 were the personalized freshman welcome letter, dental school survival kit pilot, ASDA leader holiday cards and the constituent and component campaign. Other strategies are being explored on an ongoing basis.

Office of Student Affairs. In 1995, the Board of Trustees created a special committee to develop recommendations and strategies on student membership and conversion. Based upon the recommendations made by the committee, a renewed focus has been placed on dental students, including a repositioning of the ADA Office of Student Affairs. The Council believes that the overall goal of the Office of Student Affairs (OSA) is to improve communications and strengthen relationships with dental students and to obtain a better understanding of the students' needs, concerns and interests. The Office serves as the primary ADA contact for dental students, ASDA leaders and ASDA staff, as well as ADA leaders and staff interacting with dental students. The Council approved the following three goals for the OSA:

1. establish relationships with ASDA chapter representatives to ensure that all students are aware of the importance and value of ADA membership;
2. establish a presence in the dental schools and develop a positive relationship with the dental school administration, particularly the Dean of Student Affairs; and
3. provide ADA leadership and the constituent and component societies with comprehensive information and resources to facilitate establishment of personal relationships with students.

The Council recognizes that the fulfillment of these goals and the success of the OSA requires the support and collaborative efforts of ASDA.

The Student Communications Campaign. The objective of the campaign was to increase the students' awareness and understanding of the importance of membership and to collect preliminary information regarding student needs and interests through a series of self-mailers. Each communication included a business reply card, so that students could respond to the mailing and so that preliminary information could be gathered from them. Utilizing a new approach based on the analysis of the 1995 student survey, the messages in these mailings were targeted to the needs and interests of students at each level in school.

Based on survey data, customized messages were created and mailed to freshmen, sophomores, juniors and seniors. A response rate of over 9.25% was achieved on the first mailing of this series.

Student Awareness Program. The Student Awareness Program was first implemented in 1989 and was designed to introduce students to the Association and its programs and services. As a primary component of the Student Marketing Plan, this communications activity has undergone several revisions since its implementation and is continually evaluated by the Council. In 1995-96 the program featured a "welcome to the profession" card distributed to first-year students in the fall; a customized student appointment book, sponsored by Warner-Lambert, sent to second- and third-year members; *Connections*, ADA's guide to member services, mailed to senior members; and a graduation card from President Ten Pas mailed to all senior dental students in the spring. The Office of Student Affairs was featured in each of these communications.

New Dentist Transition Program. Developed and implemented in 1993 by the Committee on the New Dentist (CND), the New Dentist Transition Program is a key component of the Student Marketing Plan. The Transition Program is based upon personal contact and is designed to assist dental school seniors in making the transition from student member to full active member. Presenters include representatives from the CND, Association staff, new dentist members from the local component society and other ADA representatives as appropriate. Seniors attending the program receive first-hand information on how to join, why to join, when to join and relevant benefits, and they have the opportunity to discuss transition issues and concerns with colleagues and peers. The 1996 program was presented in 26 schools from early February through mid-April. Participating schools included:

Case Western University
Creighton University
Howard University
Indiana University
Loma Linda University
Marquette University
Medical College of South Carolina
Meharry Medical College
Northwestern University
SUNY—Buffalo
SUNY—StonyBrook
University of Alabama
University of California—Los Angeles
University of Colorado
University of Connecticut
University of Detroit—Mercy
University of Florida
University of Kentucky
University of Maryland
University of Minnesota
University of Mississippi
University of Nebraska
University of Pennsylvania
University of Southern California
University of Washington
West Virginia University

In 1997, pending budget approval, an alternating schedule is proposed, in which the Transition Program will be presented in 27 schools one year (schools not visited in 1996) and the other 27 schools the next.

1994 Survey of Dental Students. In December 1994, the Council conducted a survey to elicit students' perceptions of the ADA and ASDA. The survey included questions that measure awareness and usage of ADA and ASDA benefits, as well as students' opinions of the Association's service in meeting their needs as dental students. A representative sample was selected from dental students in the 54 dental schools in the United States and Puerto Rico. Surveys were mailed to 6,014 dental students. Data collection was completed in April 1995. Findings of the survey include:

- Students demonstrated interest in ADA/ASDA membership, and their interest increased with each year of enrollment.
- Students rated the importance of ASDA and ADA membership in their undergraduate experience equally, while the ADA was rated more important in students' transition into practice and to their success in dental practice.
- Students are well aware of ADA/ASDA membership and indicated that they are informed of membership mostly through ASDA representatives and delegates at their schools (90%). Other sources of information include classmates (61%), ASDA publications and events (49%) and ADA publications and events (41%).
- Primary influences on students' perceptions of membership include peers (64%) and ASDA leaders (63%).
- Faculty/administration *influence* on students' decisions to join was rated lower than faculty/administration *support* of membership, suggesting that while faculty/ administration approve of ASDA/ADA membership, they have little influence on students' decisions to join.
- Among potential ADA services, students rated "financial services that would benefit students after graduation" the highest (3.7 out of 4 points). Practice management workshops, placement services and a discounted *Physician's Desk Reference* were also highly rated.
- Among marketing activities, ADA programs and events at dental schools, as well as constituent and component society participation in school activities, were highly rated.
- ADA direct mail communications to dental students were rated as useful by those students targeted to receive specific mailings.

- Most seniors underestimated the cost of full tripartite membership dues, as only 26% of seniors perceived them to be over $700.
- When asked to indicate resources that would assist graduates in starting their careers, seniors rated financial planning (over 93%), practice management resources (over 89%) and debt management skills (over 84%) most highly.

The Council reviewed the selected survey results at its June 1995 meeting. Subsequent to the 1995 annual session, the Council received the complete survey results and was asked to complete its analysis of the survey findings at its February 1996 meeting.

Based on its analysis of the survey data, the Council made appropriate revisions to the Student Marketing Plan and established the goals and objectives for the Office of Student Affairs. Additionally, the Council made several recommendations, some of which included:

- directing staff to disseminate results of the Survey of Dental Students to appropriate ADA agencies;
- requesting, through the Executive Director, that ADA FINCO be asked to target market its products and services to students as early as possible in their dental education;
- directing staff to increase communication to the Council regarding ASDA activities, such as its annual session, regional meetings and ADA-sponsored visits to dental schools; and
- recommending that the ADA continue its direct mail communications targeted to all dental students, with a particular focus on reaching first- and second-year students. Direct mail communications should be a part of the integrated Student Marketing Plan and should continue to be evaluated as an individual component of the Plan.

1996 Member/Nonmember Needs and Opinion Research: The 1995 House of Delegates approved a Council budget request to fund a comprehensive survey of Association members' needs and opinions.

The House cited the exigent need for current survey research, as the Association last conducted comprehensive opinion research in 1989. Based on the Council's need for this information, the budget package included funding for data collection from three groups: members, past members (nonrenews) and nonmembers (never members).

In January 1996, the Council on Membership, in conjunction with an outside firm and the ADA Survey Center, developed the 1996 Member/Nonmember Needs and Opinion Survey. The Council received an update on the project at its February 1996 meeting, and data collection began in May. Three follow-up mailings are scheduled and data collection is projected to be completed in August. If available, a preliminary analysis of the survey results will be reported to the House of Delegates in the Council's supplemental report. The Council will receive complete survey results at its February 1997 meeting. A summary of the survey results and the Council's analysis will be reported to the 1997 House of Delegates.

ADA Member Card Mailing: Official plastic ADA membership cards were mailed to graduated senior members. The mailing included a letter, benefits information and information on joining as full active members.

1995 Transition Training Program: In response to requests from constituent societies interested in presenting the Transition Program at dental schools in their states, the Committee on the New Dentist conducted a Transition Training Program to train constituent society staff or volunteers to coordinate and conduct Transition Programs in schools the ADA is unable to visit. In that way, the membership message is delivered to more senior dental students.

The Transition Training Program was held in two parts, both at ADA Headquarters. The first program was held on January 13, 1995 for representatives of five constituent societies: West Virginia, South Carolina, Ohio, Wisconsin and Washington. Those societies conducted Transition Programs from March through May of 1995. The second program was held December 1, 1995 for representatives of five constituent societies conducting Transition Programs in the spring of 1996: Georgia, Massachusetts, North Carolina, Oklahoma and Virginia.

Evaluations indicated that the training programs were successful, and preliminary evaluations indicated that those societies' Transition Programs were also successful.

1995 New Dentist Recruitment Campaign: The 1995 New Dentist Campaign, conducted from October 1995 through February 1996, was targeted to approximately 13,000 active licensed nonmember new dentists.

Based upon the success of the 1994 New Dentist Campaign, a similar format was used in the 1995 campaign, which utilized a combination of personalized letters and ADA publications.

The New Dentist Campaign capitalized on two "all-dentist" mailings of *JADA* and *ADA News* to communicate to nonmember new dentists. Personalized letters were sent to the target group both before and after receipt of these publications. The names and addresses of those who responded to the campaign via business reply cards were sent to state dental societies for further recruitment.

One response mechanism generated a response rate of 1.6% and preliminary conversion data shows an approximate 5% conversion rate. Conclusive conversion data will not be available until year-end.

Resolutions: This report is informational in nature and no resolutions are presented.

Division of Dental Practice

Council on Access, Prevention and Interprofessional Relations

Council on Dental Benefit Programs

Council on Dental Practice

Commission on Relief Fund Activities

Notes

Council on Access, Prevention and Interprofessional Relations

McMinn, Wallin E., Michigan, 1997, chairman
Gardner, Robert P., Ohio, 1996, vice chairman
Ashman, Steven G., Maryland, 1996
Bean, Alfred T., Illinois, 1996
Culver, Jim L., Vermont, 1999
Grubb, Richard T., Washington, 1999
Iacono, John M., New York, 1999
Lander, William W., Pennsylvania, 1996, American Medical Association
May, George W., Jr., Mississippi, 1996
McFarland, Kimberly K., Nebraska, 1997, *ad interim*
Mouden, Lynn D., Missouri, 1998
Persons, Jeffry E., California, 1997
Roberson, Theodore M., North Carolina, 1998
Staley, John H., Iowa, 1996, American Hospital Association
Steinberg, Barbara J., Pennsylvania, 1999
Steinhauer, Peter F., Colorado, 1997
Stubbs, Paul E., Texas, 1998
Zeringue, Curtis J., Louisiana, 1998
Klyop, John S., director
Marshall, James Y., assistant director
Forsberg, Jane A., manager
LaVeille, Marianne E., manager

Organization: The Council works to broaden the scope of oral health care within the health care system and to advance preventive dentistry and the delivery of oral health care in the community. The three focus areas are:

1. health care facilities and interprofessional affairs;
2. access to oral health and community health activities; and
3. fluoridation and preventive health activities.

The Council recommends policy and directs programs in these areas.

Meetings: The Council met in the Headquarters Building on September 8-9, 1995 and March 1-2, 1996. The Council is scheduled to meet again August 2-3, 1996. Three subcommittees—Access to Dental Care, Preventive Dentistry and Interprofessional Relations—meet in conjunction with regularly scheduled Council meetings.

Personnel: At the March meeting of the Council, Dr. Robert P. Gardner was unanimously elected vice chairman.

The close of the 1996 annual session brings to an end the terms of four valued members of the Council: Dr. Robert P. Gardner; Dr. Stephen G. Ashman; Dr. Alfred T. Bean; and Dr. George W. May, Jr. These members have given unselfishly of their time and energy on behalf of the profession. Their efforts are acknowledged by the Council with great appreciation.

The Strategic Plan of the American Dental Association: Each of the Council's program areas reflects the Association's Mission Statement.

Promotion of the public's health. The Council addresses this goal by developing and disseminating the Oral Health Care manuals; by representing the Association at the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to assure appropriateness of its dentistry-related standards; by encouraging and supporting development of national, state and local access programs that respond to the unmet oral health needs of the public; and by promoting scientifically proven preventive oral health programs and procedures to members and the public.

Promotion of the profession. The Council addresses this goal by recognizing the individual and collaborative efforts of member dentists responding to the challenge of increasing access to oral health care services; by strengthening the patient-dentist relationship by providing the most current information on preventive interventions for use in private offices and community-based programs; and through liaison with various health associations and governmental organizations.

Initiatives in education, research and advocacy. The Council addresses this goal by helping to assure that dentists are not discriminated against in health care facility settings by virtue of their professional degree; by sponsoring continuing education for dentists treating special patients and by

advocating for the oral health care needs of unserved or underserved population groups; by developing such resources as *Caries Diagnosis and Risk Assessment: A Review of Preventive Strategies and Management* and tobacco education resources; and by cosponsoring the National Strategic Planning Conference for the Prevention and Control of Oral and Pharyngeal Cancer and by managing the National Fluoridation Advisory Committee.

The Council's program activities support the following objectives of the Strategic Plan.

Objective 1: Legislation and Regulatory Advocacy. The Council initiates Association policy related to oral disease prevention. The cooperative relationships maintained by the Council with organizations such as the American Medical Association (AMA), American Hospital Association (AHA) and JCAHO help facilitate the Association's legislative agenda. The Council's advocacy activities in the areas of underserved and unserved population groups and fluoridation and tobacco issues are often reflected in the legislative and regulatory agenda of the Association.

Objective 2: Association Programs and Financial Plan. The Oral Health Care manuals developed by the Council and sold through the Department of Salable Materials contribute to nondues revenue. Corporate support for the Council's awards programs is also a valuable source of nondues revenue.

Objective 3: Membership Recruitment and Retention. The Council's assistance to members seeking nontraditional dental careers is a unique membership benefit and serves to retain members who are considering leaving clinical dentistry. The readily available technical assistance and resource materials provided in all the program areas are valuable membership benefits and serve to actively demonstrate the Association's commitment to disease prevention, health promotion and access to oral health care.

Objective 4: Access to Dental Care. There is a direct correlation between the activities of the Council's Access and Community Affairs Program and Objective 4. Additional activities of the Council relate directly to improving the general population's access to dental care through promotion of preventive oral health programs, community water fluoridation, access to appropriate oral health care in health care facilities and through the Oral Health Care manuals.

Objective 5: Education and Licensure. The Council addresses Objective 5 by sponsorship of continuing education activities for oral health professionals treating special patients, by development of the Oral Health Care series and by the annual sponsorship of scientific programs at the annual session.

Objective 6: Professional Image. The professional image of the Association is enhanced by the Council's awards programs, which promote dentistry's goodwill by highlighting its volunteer efforts. The Association's professional image is enhanced by acknowledging and addressing shared oral health care concerns through liaison activities with national advocacy organizations representing underserved constituencies, as well as joint ventures with the Department of Health and Human Services (DHHS), U.S. Public Health Service (USPHS), Centers for Disease Control and Prevention (CDC), National Institute of Dental Research (NIDR), National Cancer Institute (NCI) and Association of State and Territorial Health Officials. Ongoing liaison with AMA, AHA and corporate membership in JCAHO enhances the profession's stature in the health care community.

Objective 10: Associated Organizations. Program issues often necessitate close working relationships with related specialty organizations. Maintaining good working relationships strengthens the profession and expands the Association's presence and leadership in the oral health community.

Objective 12: Constituent and Component Societies. The Council's awards programs (the competitive Community Preventive Dentistry and Geriatric Oral Health Care Awards and the noncompetitive Access Recognition Award, as well as the ADA Health Foundation-sponsored Frederick S. McKay Award for Excellence in Preventive Dentistry) encourage the involvement of constituent and component societies in promoting programs which ultimately enhance their reputations in the community. The Council actively tries to enlist the participation of constituent and component societies in all areas of the Council's activities.

Liaison Activities: In addition to other activities described in this report, Council members and staff maintain liaison with various health associations and governmental organizations. These liaison activities provide opportunities to present the profession's perspective on matters of interest and to monitor and report on related activities.

Organizations with which the Council liaises and/or collaborates include: Academy of Dentistry for Persons with Disabilities; Academy for Sports Dentistry; Accreditation Association for Ambulatory Health Care; American Academy of Family Physicians; American Association of Hospital Dentists; American Association of Oral and Maxillofacial Surgeons; American Association of Public Health Dentistry; American Dietetic Association; American Hospital Association; American Medical Association; American Pharmacy Association; American Public Health Association; American Society of Geriatric Dentistry; American Student Dental Association; Association of State and Territorial Dental Directors; Centers for Disease Control and Prevention; Center for Tobacco-Free Kids; Coalition on Smoking OR Health; FDI World Dental Federation; Healthy Mothers/ Healthy Babies Coalition; Federation of Special Care Organizations in Dentistry; Joint Commission on Accreditation of Healthcare Organizations; Joint Commission on Sports Medicine and Science; Maternal and Child Health Bureau; National Alliance for Oral Health; National Cancer Institute; National Commission on Correctional Health Care; National Coordinating Committee on School Health; National

Council on the Aging; National Dental Tobacco-Free Steering Committee; National Foundation of Dentistry for the Handicapped; National Health and Education Consortium; National Health Service Corps; National Heart, Lung and Blood Institute; National High Blood Pressure Education Program Coordinating Committee; National Institute of Dental Research; National Network for Oral Health Access; National Oral Health Information Clearinghouse Coordinating Committee; U.S. Olympic Committee; U.S. Public Health Service; U.S. Surgeon General's Office; and the World Health Organization.

Nonclinical Dental Career Information: The Council provides information and guidance to dentists who are interested in pursuing a nonclinical or nontraditional dental career. A resource package is provided which discusses, in general terms, the issues and factors dentists need to take into consideration when investigating a nonclinical career. The Council reviewed the resource materials at its March meeting and made no significant changes. Each year the Council office receives 500-600 requests for this information.

Interprofessional Relations

Related Activities of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO): Dr. John F. Helfrick continues as the Association's Commissioner on the Joint Commission. He is also vice chairman of the Board of Commissioners. Dr. Helfrick serves on JCAHO's Executive Committee, the Finance and Audit Committee, the Standards and Survey Procedures Committee, the Action Plan Oversight Committee and the Accreditation Committee. He routinely attends the Council's meetings and reports on JCAHO activities of interest.

The Association is well represented on numerous Joint Commission committees and task forces. Currently, Dr. John Kelly is vice chairman of the Hospital Accreditation Program Professional and Technical Advisory Committee (PTAC) with Dr. Steven G. Ashman serving as alternate; Dr. Barry Ceridan serves on the Long Term Care Accreditation Program PTAC with Dr. Joseph G. Kalil serving as alternate; Dr. Eugene W. Seklecki serves on the Ambulatory Accreditation Program PTAC with Dr. George W. May serving as alternate; and Dr. Wallin E. McMinn serves on the Home Care Accreditation Program PTAC with Dr. Marie Jacobs serving as alternate. Serving on the Mental Health Program PTAC is Dr. David A. Tesini with Dr. John A. Hendry as alternate. And finally, serving on the Health Care Network PTAC is Dr. Albert H. Guay with Dr. Richard Haught as alternate.

In 1995 a meeting of the PTAC representatives was held during the ADA annual session. Dr. Helfrick proposed the meeting as a means of facilitating the work of the representatives on behalf of the Association. The Council plans to organize such a meeting again this year for all PTAC representatives who are attending the annual session.

Association volunteers and/or staff attend each of the JCAHO meetings of the committees identified above. These meetings are attended by other major health care delivery and provider organizations, which affords dentistry's representatives the opportunity to solidify the profession's role within the health care delivery picture.

JCAHO Surveyor Training. The Council produces a half-day seminar for new Joint Commission surveyors on the role of dentistry and dental departments in the operation of health care facilities. Particular attention is devoted to how JCAHO standards apply to dentistry. Faculty for this seminar includes Dr. Peter S. Hurst, chairman of the Department of Dentistry at Northwestern Memorial Hospital in Chicago, and staff from the Council. This program is presented two or three times each year.

Accreditation Association for Ambulatory Health Care (AAAHC): Late last year, AAAHC invited the Association to send an observer to its Board of Directors meeting. Association president Dr. William S. Ten Pas named Dr. Alfred T. Bean to represent the Association in this capacity. AAAHC is a private organization specializing in accrediting ambulatory care and surgical center facilities. A small number of private dental offices are accredited by this body. Dentistry is represented formally on the AAAHC Board by representatives from the American Academy of Dental Group Practice and the American Association of Oral and Maxillofacial Surgeons.

Hospital Dentistry Issues: The Council monitors and responds to problems related to medical staff membership and/or privileges based on inappropriate hospital bylaws language. An ongoing effort is aimed at identifying and revising, where possible, discriminatory bylaws language in individual hospitals or in sets of model bylaws maintained by state medical societies. When necessary, the Association's Department of Legal Affairs assists in helping individual dentists resolve adverse situations.

A report on the Council-sponsored survey of U.S. hospitals was published in January. The Association's Survey Center sent the survey questionnaire to 3,000 hospitals in all regions of the country. The survey sought information on the scope and nature of dental departments in hospitals and the services they rendered. The report noted, for example, that 98% of hospitals that provide dental services have bylaws permitting dentists to be members of the medical staff. Of that same group of hospitals, 83% have dentistry organized as a separate department. In a related survey of dentists conducted by the Survey Center, it is noted that in 1995 nearly 30% of the Association membership reports having hospital privileges.

National Health Service Corps: At the direction of the Council, staff developed a handbook on the National Health Service Corps (NHSC) and the health professional shortage area designation process. The handbook, finalized at the Council's September 1995 meeting, is designed for use by dental societies and individual dentists with questions about this program. It was distributed to constituent dental societies in January of this year.

The Council has been concerned about the fact that many dentists who want to participate in the NHSC Loan Repayment Program are unable to do so because there are not enough qualified shortage areas that apply for dentists through the program. The Loan Repayment Program contracted with 90-100 dentists in 1995, but a backlog of willing dentists remains. At the same time, there are many questions and misconceptions about how the NHSC works and how areas become qualified to receive a NHSC dentist. The handbook will help clarify the operation of the NHSC and the Loan Repayment Program.

The Council also considered the issue of Association support for the NHSC Scholarship Program. Throughout the 1980s the Association maintained a policy opposed to the NHSC Scholarship program (*Trans.*1981:577). In 1988 the House of Delegates rescinded that policy (*Trans.*1988:488). Given the growing burden of dental school debt, the Council revisited this issue as at least one option that dental students might use to lessen the long-term costs of dental education.

Oral Health Care Manuals Development: The Council is continuing to develop new and revise existing Oral Health Care manuals pertaining to patients with complex medical conditions. The Council authorized the development in 1995 of a manual on the unique oral health care problems of women, which was published in December. The Council wishes to express its appreciation to Dr. Barbara J. Steinberg, who was the principal author of this new publication.

The Council's Committee on Oral Health Care Manuals Development has completed revisions to four existing manuals in 1996 and has begun work on at least one new title. The Council authorized publications on geriatric patients and transplant patients for the Oral Health Care Series.

American Medical Association: Council staff attends both the annual and interim meetings of the AMA's House of Delegates and the Organized Medical Staff Section. Association president Dr. William S. Ten Pas appointed Dr. William E. Allen to replace Dr. Lewis S. Earle as the Association's official observer to the AMA House of Delegates. Dr. Earle stepped down after four years of service. The Council expresses its gratitude to Dr. Earle for his work on behalf of the Association.

American Hospital Association: The Council also maintains liaison with the American Hospital Association, and staff attends its annual membership and other appropriate meetings. The Association's official observer to the AHA, appointed by Dr. Ten Pas, is Dr. Gerald Laboda. Dr. Laboda participated in the 1996 AHA membership meeting in Washington, D.C. and reported to the Board of Trustees by way of a letter to Dr. Ten Pas.

American Association of Oral and Maxillofacial Surgeons: The Council participates in the American Association of Oral and Maxillofacial Surgeons' (AAOMS) Hospital Committee at least once each year. At its March meeting, the Council considered a request from AAOMS asking the Council to assist it in verifying to the medical community and state medical licensing boards that certain surgical procedures, such as bone grafting and facial cosmetics, can and do fall within the scope of practice of a properly trained oral and maxillofacial surgeon. The Council believed that the request would more appropriately be handled by the Council on Dental Education and, therefore, referred it through the Office of the Executive Director.

National Nondental Health Care Professional Associations and Organizations: In 1996, the Council launched an effort to expand its liaison activities with national nondental health care professional associations and organizations. An update on this activity was provided to the Board of Trustees at its April meeting. This initiative is intended to create a line of communication and to foster greater opportunities for cooperative efforts on issues of mutual interest. It is also intended to explore the potential for offering continuing education programs on oral health and to discuss the inclusion of oral health in the core curricula of various nondental health care disciplines as recommended by Resolution 20H-1995 (*Trans.*1995:609).

Migrant and Community Health Centers: Last fall the Association was invited to attend a meeting sponsored by the USPHS Bureau of Primary Care to review the current oral health policy for migrant and community health centers. Dr. Ten Pas appointed Dr. Michael Till, Tenth District trustee, to represent him at this meeting. The Council provided staff support. To date, the proceedings of this meeting have not been published but are expected to include recommendations for strengthening the dental requirements of the current regulations dealing with migrant and community health centers. At its March meeting, the Council voiced support for the concept of improving these regulations and will offer specific comments to Dr. Till on the final recommendations when they become available.

Access and Community Affairs

Access to Oral Health Care: The Council's goal regarding access to care is to help ensure that special population groups which need and want oral health care are able to receive it. To meet this goal, the Council identifies and promotes innovative programs to make care more accessible to individuals who are economically disadvantaged, disabled, homebound and/or institutionalized. Recognizing that the Association itself cannot deliver care, the Council serves to identify oral health needs and to foster appropriate outreach programs to meet those needs consistent with the Association's policies.

In addition to promoting public awareness of the oral health needs of vulnerable populations, the Council provides technical assistance and counseling to dental societies, dental schools, individuals and organizations interested in development, implementation or maintenance of an access initiative. Further, the Council recommends and reviews legislation aimed at improving the availability of oral health care services to special patients; develops and distributes

professional and patient resource materials; and sponsors continuing education activities for the dental team.

Association Endorsement of Access Programs: Over time, the Council has received a number of requests from access program directors for Association endorsement of their programs. As a result, the Council developed criteria for evaluating these requests. The Council's primary motivation in developing these criteria was to assist access programs as they pursue their mission and goals while minimizing the Association's exposure to risk. Secondarily, the Council was interested in enhancing the Association's public image as a result of the publicity that often accompanies program endorsement.

In 1995, following development of the Council's criteria, the Council received a request for Association endorsement from Kids in Need of Dentistry (KIND). KIND is a not-for-profit charitable health organization for children which operates in the Denver metropolitan area. Its mission is to provide quality dental care to children from families of marginal income who do not receive public assistance and are not covered by dental insurance.

The Council reviewed KIND's endorsement request and following careful consideration forwarded a recommendation to the Association's Board of Trustees strongly encouraging it to grant KIND endorsement. Further, the Council recommended that KIND be granted permission to use the Association name and logo in materials to be used for promotional and/or fund-raising purposes, pending development of an appropriate license agreement with KIND. The Board of Trustees, in April, deferred consideration of KIND's endorsement request until its July session to allow time to develop a uniform set of criteria that would govern its consideration of various endorsement requests.

Affiliation with the National Foundation of Dentistry for the Handicapped (NFDH): The Council functions as the Association's primary liaison with the Foundation, an affiliate of the Association since 1988. The Foundation's executive director, Dr. Larry Coffee, serves as a Council consultant and regularly reports to the Council on NFDH programs.

The Foundation develops and implements dental care programs for the elderly and for mentally and physically handicapped individuals of all ages. The Foundation currently sponsors oral health programs in 15 states.

In addition to the 15 states with active projects, dental associations in three other states have sanctioned development of Donated Dental Services (DDS) programs. Two additional associations are considering such action. The Foundation is also using its own resources to establish a limited "national" DDS project. Through it, volunteer dentists will be sought for needy disabled, elderly and medically compromised people in states without a DDS project. This project is only a supplement to continued efforts at expanding the DDS program to additional sites.

During fiscal year 1994-95, 35,000 people received $3.8 million in oral health services through the Foundation's three major programs: Donated Dental Services (DDS), Dental HouseCalls and BRIDGE (formerly the Campaign of Concern). Approximately $2.5 million of donated treatment was provided by the more than 5,000 volunteer dentists and 850 laboratories participating in the DDS projects.

The Foundation's programs are relevant in any area of the country. They use dental and financial resources that are available to help vulnerable people unable to get needed care. Constituent and component dental societies can request the Foundation's services to help plan, raise money for and implement any of its model access programs. Approval by the constituent dental society is the Foundation's only requirement for working, at its own expense, to organize a project.

By virtue of the affiliation agreement, the Association appoints and maintains three representatives on the 17-member NFDH Board of Trustees. They are: Dr. Ross J. DeNicola, Jr. (term expires June 30, 1998); Dr. Frank A. Maggio (term expires June 30, 1997); and Dr. David A. Whiston (term expires June 30, 1996).

DentaCheques. Beginning in 1990, the Foundation has been actively marketing the sale of a dental product coupon book called DentaCheques as a fund-raising activity. This successful activity is in its sixth year, with the 1997 edition already well underway. Various Association agencies help to promote this ongoing activity.

1995 Survey Activities: The Council continues its efforts to collect information about dentistry's access activities nationwide.

1994 Survey of Dental Practice (SDP). The 1994 *SDP* was sent out by the Association's Survey Center to 6,821 private practice dentists—4,564 general practitioners and 2,257 specialists. The dentists were asked if their primary practice provided dental care services free of charge or at a reduced rate to a variety of underserved populations. The results were reported in a *Special Report on Free/Discounted Dental Services*.

1995 Survey of Current Issues in Dentistry. In 1995, in collaboration with the Survey Center, the Council sought to collect information on the number of dentists providing dental care to individuals in out-of-office settings. These settings include hospitals, homeless shelters, assisted living centers, senior residential communities, nursing or convalescent homes, patients' homes, hospices and adult day care centers. A special report on this subject, *1995 Survey of Current Issues in Dentistry: Treatment of Long-Term Care Facility Patients*, was distributed by the Survey Center in May.

1995 Survey of State Dental Programs in Medicaid. At the request of CAPIR, the Council on Dental Benefit Programs (CDBP) included a question on its *1995 Survey of State Dental Programs in Medicaid* regarding post-eligibility treatment of income (PETI). The information obtained in past surveys, albeit minimal, has been of value to the Council as it attempts to collect and disseminate information about ways in which the various state Medicaid programs have implemented the PETI provision, if at all.

White House Conference on Aging (WHCoA): The fourth White House Conference on Aging was convened on May 2-5, 1995 under the terms of the Older Americans Act, which authorized that such a conference be held. More than 2,000 voting delegates and approximately 250 official observers with no voting power attended. At least eight member dentists attended, either as organizational representatives or as part of state delegations.

The Conference resulted in 51 resolutions. Although there are no resolutions specific to oral health, three resolutions do contain language referencing dental care. Additionally, there are a number of resolutions that contain language mentioning health care providers, health professionals, health professional schools, access to care, health promotion, disease prevention and health care financing.

The Council noted that there are numerous Association policies and programs that serve to support the essence of many of the WHCoA resolutions from a dental perspective. Various agencies of the Association, along with its constituent and component dental societies, have a long history of advocating for the oral health and well-being of older adults. However, these efforts are not always well-recognized.

As a result, the Council will encourage each constituent dental society to forward information to its respective governor which highlights the profession's long-standing efforts to advocate for the oral health and well-being of older adults.

Collaboration with the ADA Health Foundation (ADAHF): During 1994, the ADAHF expanded its mission to include funding of access initiatives. Since that time, the Council has been working closely with the ADAHF to develop the necessary policies and procedures for achieving this mission. In late 1995, the Council assisted the ADAHF with the revision of a grant review form. The Council looks forward to future CAPIR/ADAHF collaborations.

National Council on the Aging (NCOA): For many years, the Council has maintained liaison with NCOA. The NCOA is a private, not-for-profit organization, established in 1950, that serves as a national resource of information, training, technical assistance, advocacy and research on every aspect of aging. Council staff attended the 1996 NCOA Annual Conference held in April in Washington, D.C.

Through its participation in NCOA activities, the Association gains valuable insight, input and visibility on issues of significance to older adults.

National Commission on Correctional Health Care (NCCHC): The Association, through the Council, maintains liaison with the NCCHC and is one of its supporting organizations. The NCCHC provides health care accreditation services for participating jails, prisons and juvenile correctional facilities nationwide. Dr. William J. Byland is the Association's representative to the Board of Directors of the NCCHC. He is a member-at-large of NCCHC's Executive Committee, as well as a member of the Board of Trustees of the Certified Correctional Health Professional Committee. The Council is extremely grateful to Dr. Byland for his ongoing efforts on behalf of the Association.

Working with Dr. Byland, the Council provides assistance to the NCCHC on issues of mutual interest pertaining to the oral health of incarcerated individuals. The Council recently provided input into the revision of the *Standards for Health Services in Prisons*, due to be published in 1997.

National Alliance for Oral Health (NAOH): The Association, through the Council, has also maintained liaison with the National Alliance for Oral Health. The NAOH is a not-for-profit organization made up of voluntary health groups, professional health-related organizations and individuals concerned with the oral health needs and problems of people with systemic diseases and disabling conditions. The mission of NAOH is to improve the oral health of special patient populations through increased access to early comprehensive diagnosis, prevention strategies and appropriate therapies. Council staff currently holds a two-year at-large position on the Board of Directors.

The Alliance regularly submits testimony in support of funding for dental research, inclusion of medically necessary oral health care in any health system reform package under consideration by Congress and continued funding for dental education programs.

National Oral Health Information Clearinghouse (NOHIC): NOHIC is a resource for patients, health professionals and the public seeking information on the oral health of special care patients. A service of the National Institute of Dental Research, NOHIC gathers and disseminates information from many sources, including voluntary health organizations, educational institutions, government agencies and industry. NOHIC is instrumental in marketing existing Association resources to consumers.

NOHIC is in its third year of operation. In its first year, NOHIC's primary focus was on developing systems, procedures, resources and publications; stimulating interest and inquiries; and announcing the clearinghouse to the oral health and special care communities as a new information service. In its second year, NOHIC shifted its emphasis to include outreach and promotional efforts, with continued resource and material development. Also during its second year, 35% of requests to the clearinghouse were made by dentists; 30% by patients, family and friends; 13% by librarians; 9% by nondental health professionals; 4% by hygienists/assistants/technicians; and 3% by health educators.

The Association is represented by Council staff on the Coordinating Committee for the National Oral Health Information Clearinghouse. The next meeting of the Coordinating Committee is to be held during autumn 1996.

Council Award Programs: The Council administers a number of award programs designed to recognize those individuals and/or entities that have successfully furthered the Council's goals.

Access Recognition Award Program. In 1989, the Council launched an ongoing program designed to honor individuals

who have shown particular leadership and inspiration in the establishment of local access programs.

To date, 79 individuals from 29 states and Puerto Rico have received recognition. Recipients in 1995 were: Dr. J. Don Harris, Oklahoma; Dr. Lynn A. Jones, Dr. John J. McFatridge and Dr. Robert R. Shaw, Washington; Dr. Mark J. Bruzek, Dr. Randy R. Ciepluch, Dr. Joseph L. Kotnour, Dr. Paul D. Vander Kelen, Dr. Jeffrey R. Jones, Dr. Joseph R. Theisen, Dr. Lonnette S. Breneman, Mr. Doug Mormann and Mr. Gregory Nycz, Wisconsin; and Ms. Barbara Garrison, North Carolina. Award recipients receive a wall plaque containing a certificate signed by the Association's Executive Director as well as a mention in various Association publications.

In January, the Council aggressively promoted this program to constituent dental societies and asked them to nominate outstanding individuals to be recognized during 1996. The Council has received numerous nominations in response to its request. This program assists the Council in identifying the increasing number of programs that provide oral health services to underserved individuals.

Community Preventive Dentistry Award. The Community Preventive Dentistry Award, funded by Johnson & Johnson Professional Division, a Division of Johnson & Johnson Consumer Products, Inc., and administered by the Council, recognizes significant preventive dentistry programs. Four programs were recognized during 1995, the 23rd year of the program. The highest award of $2,000 was presented to the Illinois Department of Public Health's "Project Mouthguard." Meritorious awards were granted to three worthy programs: Free Dental Clinic at Homeless Emergency Project in Clearwater, Florida; Matthew 25 Dental Clinic in Fort Wayne, Indiana; and Health Care Network, Inc., of Racine, Wisconsin.

On behalf of the Association, the Council wishes to thank Johnson & Johnson Consumer Products, Inc. for its generous and ongoing support of this program.

Geriatric Oral Health Care Award. The Geriatric Oral Health Care Award, funded through a grant from the Warner-Lambert Company Consumer Health Products Group, recognizes those individuals and organizations that have improved the oral health of older adults through innovative health care delivery projects. In 1995, the highest award of $2,000 was presented to the Wilder Senior Dental Program of St. Paul, Minnesota. No meritorious awards were granted.

The Geriatric Oral Health Care Award program has been restructured for 1996. The highest award will be $2,500; one meritorious award of $500 may also be granted.

On behalf of the Association, the Council wishes to thank Warner-Lambert Company Consumer Health Products Group for its generous and ongoing support of this program.

Council's Choice Award. In 1993, the Council developed and awarded the first Council's Choice Award. The award is a noncompetitive award given at the Council's discretion and issued to individuals, organizations, corporations and/or programs in recognition of their outstanding efforts in the areas of access and community affairs, fluoridation and preventive health activities and institutional and interprofessional affairs. The award is not an annual award, but rather, is given only when the Council deems appropriate.

In 1996, the third Council's Choice Award will be given to California Assemblywoman Jackie Speier. Ms. Speier was the sponsor and main political force behind the successful legislation to fluoridate water supplies in California communities with populations of 25,000 or more. Passage of this legislation has widespread implications for the future of community water fluoridation in the United States. This is perhaps the most notable outcome of Ms. Speier's efforts. California's achievement has already motivated public health officials in some sparsely fluoridated northeastern states to wage large-scale efforts to initiate water fluoridation in those areas.

Ms. Speier, a California Assembly member for ten years, represents northern San Mateo County, an area just south of San Francisco. A member of the California Fluoridation Task Force and a parent of two children, she was concerned because so few communities in California were fluoridated. In her capacity as a public official, Ms. Speier became aware that considerable public funds were spent each year to repair dental disease that is completely preventable. Because of her special contributions to dentistry through sponsorship of the 1995 state water fluoridation bill, the Council chose to honor Ms. Speier with its Council's Choice Award.

The Council expresses its heartfelt congratulations to all of the award recipients.

Fluoridation and Preventive Health Activities

Fluoridation Activities: The Council serves as the focal point for fluoridation activities within the Association and acts as a resource to the profession and the public on this issue. This year, the Council provided educational materials and assisted active campaigns to initiate or retain fluoridation in 95 communities in 30 states.

California Fluoridation Law: The Council expended a variety of resources this year to assist CDA in adoption of legislation to mandate statewide fluoridation. This is the first state fluoridation law that has passed in over 20 years and is an important victory for the future of water fluoridation. Promotion of fluoridation across the country will be aided by California's success.

In addition to staff providing weekly technical assistance over the telephone, the Council sent complimentary materials to several California communities. Council consultants were relied on heavily by CDA to provide testimony to various committees in the state legislature.

Fluoridation Quality and Infrastructure: The 1995 House of Delegates adopted Resolution 3H-1995 (*Trans.*1995:609), urging several essential actions to maintain the quality of community water fluoridation. One of those recommended actions is observance of the Centers for Disease Control and Prevention's *Engineering and Administrative*

Recommendations for Water Fluoridation—1995 by fluoridated water systems in all states. These recommendations were published in the September 29, 1995 *Morbidity and Mortality Weekly Report*. By copy of a letter to the CDC, all state public health dental directors were informed of the Association's new policy statement on fluoridation quality and infrastructure.

New Fluoridation Audiovisual Materials: The Council completed a year-long project to develop a new community water fluoridation audiovisual presentation. Given that only 62% of U.S. water systems are fluoridated, these materials will serve as a useful promotional and educational resource for many years. The presentation will be available in both English and Spanish versions and will be sold through the *ADA Catalog* in both videotape and slide series format. Funded by the Council, the materials were developed in collaboration with the Department of Media and Creative Services and the Department of Salable Materials. Technical review was provided by members of the Council's National Fluoridation Advisory Committee and the CDC's Oral Health Program.

The Council also worked this year with the Association's Division of Communications to develop several fluoridation and fluoride articles for the Association's *Dental News Digest* on the World Wide Web. In monitoring antifluoridationist publications, the Council found that fluoride opponents maintain at least 60 home pages on the World Wide Web. At its March 1996 meeting, the Council discussed adding several pieces of pro-fluoride consumer information to the Association's home page as part of its development of additional resources and materials.

National Fluoridation Advisory Committee (NFAC): The NFAC meets annually and is composed of consultants to the Council. This Committee continues to serve the important role of assisting the Council with proactive national community water fluoridation activities. In this regard, NFAC assists the Council in monitoring scientific and community-based trends associated with the state/local water fluoridation initiatives and provides the Council with valuable input in the development and/or revision of fluoride/fluoridation education materials. This year's NFAC meeting will be held on June 28, 1996. The following members are serving one-year terms on the NFAC: Dr. Lynn D. Mouden, chairman; Dr. Stephen B. Corbin; Dr. Michael W. Easley; Dr. Herschel Horowitz; Dr. Elaine Neenan; Dr. Ernest Newbrun; Mr. Thomas Reeves; and a representative from the National Institute of Dental Research.

Celebration of the 50th Anniversary of Water Fluoridation: During 1995 the Council concluded activities related to Resolution 130H-1993 (*Trans.*1993:692) to identify opportunities for the Association to be visibly associated with the celebration of the 50th anniversary of community water fluoridation. On September 15-16, 1995, an international symposium relating to the 50th anniversary of community water fluoridation was held in Grand Rapids, Michigan. The then president, Dr. Richard D'Eustachio, was present on behalf of the Association. In planning for the event, Council staff provided considerable assistance and information to staff of the Michigan Dental Association and members of the West Michigan Dental Society, including correspondence and technical assistance.

In addition to the symposium, a commemorative marble monument was dedicated. In response to Resolution 126H-1994 (*Trans.*1994:675), the Association, through the Council, allocated $25,000 to support the commemorative monument. The monument contains educational information about the history of water fluoridation and was placed in a park on the banks of the Grand River in downtown Grand Rapids. The Association's name is engraved on the monument, along with other benefactors. This celebration of community water fluoridation will continue to give positive attention to the Association and to dentistry with the permanent presence of the commemorative monument.

National Fluoridation Awards: The National Fluoridation Awards are sponsored by the CDC, in cooperation with the American Dental Association and the Association of State and Territorial Dental Directors. Awards are presented annually during the National Oral Health Conference to recognize the contributions made by states and/or individuals in advancing community water fluoridation. During the 1996 National Oral Health Conference, awards were presented to California Assemblywoman Jackie Speier, the California Fluoridation Task Force and the California Dental Association to recognize their efforts in successfully passing legislation to mandate fluoridation in large California communities. Awards were presented to eight individual water systems that are celebrating 50 or more years of fluoridation in 1996. These water systems are in Illinois, Michigan, New York and Wisconsin.

School Health Issues: Since 1993, the Council has represented the Association at meetings of the National Coordinating Committee on School Health (NCCSH). This national delegation was brought together by the U.S. Department of Health and Human Services, the U.S. Department of Education and nongovernmental organizations to support quality comprehensive school health programs in the nation's elementary and secondary schools.

On behalf of the Association, Council consultant Dr. James J. Calderone attended the June 13-14, 1995 and the March 29, 1996 meetings of the NCCSH. Main topics discussed at the June meeting included funding for education, financing school-based health centers and problems that school-based health centers create for schools. The March meeting focused on selling and supporting school health programs.

The Council will continue to participate in these conferences to:

1. be on the forefront of school health initiatives related to oral health;
2. monitor discussions of federal and state legislation affecting school health programs; and
3. provide important technical assistance related to oral health promotion and education.

Child Abuse/Family Violence: The Council works in collaboration with the Council on Dental Practice (CDP) on issues related to the prevention of family violence and child abuse. During 1995-96, the Council continued initiatives in response to Resolution 141H-1993 (*Trans.*1993:707), which called upon Association agencies to develop resource material and educational courses to assist members in becoming more familiar with the physical signs of child abuse. At the Council's urging, the Association's Survey Center included four questions on identifying child abuse in its 1995 *Survey of Current Issues in Dentistry*. Also at the urging of both CAPIR and CDP, the Association's Department of Seminar Services offered a 1995-96 course entitled "Dentistry's Role in Preventing Child Abuse and Neglect."

CAPIR and the Council on Communications have begun development of a child abuse and neglect resource kit. Preliminary plans are to include resources related to recognizing physical signs of child abuse, continuing education and identifying appropriate reporting agencies in each state. Copies of the kit will be produced and distributed to state dental societies.

In early 1995, the Council took action to cosponsor, with CDP, a Second National Conference on Dentistry's Role in Preventing Child Abuse and Neglect, tentatively scheduled for May 1997. It is anticipated that the Association will be the sole sponsoring agency, with CAPIR and CDP providing staff resources. The ADA Health Foundation has conditionally approved its financial support for the conference pending procurement of matching funds.

In conjunction with constituent dental societies, the Council continues to advocate for the development of state P.A.N.D.A. (Prevent Abuse and Neglect through Dental Awareness) coalitions. P.A.N.D.A. trains dentists and their staff members to recognize and report suspected victims of child abuse. The first P.A.N.D.A. program was founded in Missouri in 1993 as a public/private partnership with Delta Dental Plans of Missouri, the Missouri Bureau of Dental Health and the Missouri Dental Association, among others. Approximately 30 P.A.N.D.A. coalitions have developed since 1993.

Pit and Fissure Sealants: The Council continues to provide Dental Sealant Resource Kits to members upon request. On an ongoing basis, the Council works with other Association agencies to communicate information about sealants to the membership.

The Council worked with the Council on Scientific Affairs (CSA) to develop a revised Association report, *Dental Sealants*. The last dental sealant report coauthored by CAPIR and CSA was published in May 1987. Since then, a considerable amount of new data has been published on the effectiveness and retention of dental sealants, including data supporting sealant use in adults who are at high risk for pit and fissure caries. The Councils on Communication, Dental Education, Dental Practice and Dental Benefit Programs have agreed to review *Dental Sealants*. Pending approval by all involved Councils, the final version of the Association report could be published in the November or December 1996 issue of *The Journal of the American Dental Association*.

The Council also monitors the provision of dental sealants in the public sector through school-based or school-linked health centers. Currently there are about 125 public health sealant programs across the country. The number has expanded over the past several years for the purpose of increasing the prevalence of sealants in children with limited access to oral health care and as a means to meet the Healthy People 2000 sealant objective.

Baby Bottle Tooth Decay and Early Childhood Caries: Over the past year the Council considered several actions to respond to Resolution 63H-1995 (*Trans.*1995:632), Prevention of Baby Bottle Tooth Decay. As directed by the resolution, the ADA Board of Trustees reviewed the Council's proposed program activities during its April 1996 meeting and will consider them further during the budget approval process.

Preventive Health Policy Statements: In March 1995, the Council began an analysis of the Association's policy statements regarding prevention, nutrition and school health.

The Council's evaluation revealed that several policy statements adopted in the 1960s and 1970s should be rescinded to eliminate redundancy and update the positions presented. In their place, the Council proposed new policy statements that maintain the salient points from the Association's existing policies while presenting more current health promotion concepts.

The Council, therefore, recommends adoption of the following resolutions.

2. Resolved, that with respect to nutrition and oral health, the Association encourage dentists to maintain current knowledge of nutrition as it relates to general and oral health and disease, and be it further

Resolved, that the Association encourage dentists to effectively educate and counsel their patients about proper nutrition and oral health, including eating a well-balanced diet and limiting the number of between-meal snacks, and be it further

Resolved, that the Association encourage constituent and component dental societies to work with school officials to ensure that school food services, including vending services and school stores, provide nutritious food selections, and be it further

Resolved, that the Association oppose targeting children in the promotion and advertisement of foods low in nutritional value and high in cariogenic carbohydrates, and be it further

Resolved, that the Association encourage continued federal support for programs that provide nutrition services and education for infants, children, women and the elderly, and be it further

Resolved, that the Association encourage the appropriate government agencies to prevent the distribution of non-nutritious and highly cariogenic foodstuffs under federal nutrition service programs, and be it further

Resolved, that Resolution 27-1973-H (*Trans.*1973:659), Sale of Sugar-Rich Products in Schools; Resolution 28-1973-H (*Trans.*1973:660), Food Product Labeling; Resolution 56-1974-H (*Trans.*1974:687), Amendment to National School

Lunch Act and Federal Food Stamp Program; Resolution 24H-1978 (*Trans.*1978:500), Statement on Advertising of Sugar-Rich Products to Children over Television; Resolution 129H-1978 (*Trans.*1978:510), Reference to Sugar Substances in School Textbooks; Resolution 98H-1979 (*Trans.*1979:625), Report to the House of Delegates of Task Force on the Prohibition of the Sale of Confections in Schools; and Resolution 8H-1983 (*Trans.*1983:544), American Dental Association Support of Child Nutrition Programs, be rescinded.

3. Resolved, that the American Dental Association encourage elementary and secondary schools to integrate current principles of oral health and disease prevention throughout their health education curricula to increase awareness and knowledge of oral health and to promote behaviors that reduce the risk of oral disease or injury, and be it further
Resolved, that constituent and component dental societies be encouraged to work with the appropriate health and education officials and agencies in their communities to achieve these goals, and be it further
Resolved, that Resolution 40-1960-H (*Trans.*1960:234), Health Education in School and College Curricula; Resolution 45-1971-H (*Trans.*1971:525), Prevention of Dental Disease; and Resolution 54-1972-H (*Trans.*1972:670), Prevention in School Curriculums, be rescinded.

Sports Dentistry: The Council remains committed to promoting a greater awareness of sports dentistry issues and encourages widespread use of orofacial protectors. The Council maintains information on sports dentistry, including orofacial protectors; sports sanctioning bodies' rules and regulations; risks of smokeless tobacco use; and the U.S. Olympic Committee's (USOC) Dental Consulting Group.

The Dental Consulting Group to the Sports Medicine Committee of the USOC met on March 28-29, 1996. The Dental Consulting Group is chaired by Dr. W. Robert Biddington and includes Dr. James Lonborg and Mr. Nikolaj Petrovic.

The ADA Publishing Company will publish a Special Report in the June 1996 issue of *The Journal of the American Dental Association* on "Dentistry and Sport," to coincide with the 1996 Olympic Games in Atlanta. Planned are articles on "Sports Dentistry: The Profession's Role in Athletics" by Dr. Jackson Winters; "Sports and the Dental Office: Practice-Building Opportunities" by Dr. Ray Padilla; "Emergency: Dealing with Sports-Related Dental Trauma" by Dr. Joe Camp; and "The Role of Organized Dentistry: The ADA and State Societies" by Dr. David Kumamoto and Mr. John Klyop.

Hypertension: Dr. Brodie Secrest, Jr., Council consultant, is a member of the National High Blood Pressure Education Program Coordinating Committee (NHBPEP). The issue of hypertension and dentistry's role in hypertension screening continues to be an important health promotion issue addressed by the Council. On behalf of the Association, Dr. Secrest attended the NHBPEP Coordinating Committee meeting on March 22, 1996. Dr. Secrest informed the Committee of the Association's revised policy (*Trans.*1995:610) on hypertension screening, Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program.

Tobacco Issues: The Council represents the American Dental Association on several national steering committees and work groups dedicated to promoting the dental profession's involvement with a variety of tobacco-related issues. These groups include the National Dental Tobacco-Free Steering Committee, the Healthy People 2000 Tobacco Workgroup and the National Cancer Institute/National Institute of Dental Research Steering Committee on Spitting Tobacco and Baseball. The Council, on behalf of the Association, has also supported, in principle, several nationally recognized tobacco use prevention and intervention programs designed for both the profession and the public.

Smokeless Tobacco. As a result of the Association's long-standing commitment to smokeless tobacco education and awareness, the Council remains involved with several national efforts (as noted above) designed to increase the public's awareness about the hazards associated with smokeless tobacco use. Additionally, the Council continues to distribute its Smokeless Tobacco Resource Kit, which is available to dentists on request. The Council distributed approximately 100 smokeless tobacco resource kits this past year.

The Council continues to monitor articles and commentary promoting the notion of smokeless tobacco use as an acceptable smoking cessation technique. The Council continues to believe that the weight of scientifically sound evidence does not support the use of smokeless tobacco as a smoking cessation technique. The Council issued a statement to that effect in March 1996. The statement was made available to state dental societies and to the media.

Tobacco Cessation. On an ongoing basis, the Council identifies opportunities for involving the Association with activities designed to support Association policy relating to tobacco use prevention in the dental environment. The Council distributes a Tobacco Cessation Resource Packet, which contains informational materials on smoking cessation and tobacco intervention programs suitable for implementation in a dental office setting. This packet is available to members upon request. The Council distributed nearly 100 tobacco cessation packets this past year.

Resolution 86H-1995, originally submitted by the Council, was adopted by the 1995 House of Delegates (*Trans.*1995: 609). This updated policy affirmed nicotine (in place of the word *tobacco*) as an addictive drug and encouraged support for the prompt enactment of legislation authorizing the Food and Drug Administration (FDA) to regulate tobacco products as nicotine delivery devices and/or drugs.

In response to Resolution 86H-1995, the Council provides technical expertise and assists the Council on Governmental Affairs and Federal Dental Services in advocating for tobacco use prevention through federal and state legislation. In December 1995, correspondence was sent from the Association to the Commissioner of the FDA in support of the

proposed tobacco regulations. Also, in concert with the Washington Office, the Council supports the efforts of the Coalition on Smoking OR Health and the Campaign for Tobacco-Free Kids. During its March 1996 meeting, the Council discussed how other national health organizations have filed friend of the court briefs to support the tobacco litigation taking place throughout the country.

Oral Cancer Initiatives: On August 7-9, 1996, a "National Strategic Planning Conference for the Prevention and Control of Oral and Pharyngeal Cancer" will be held in the Headquarters Building. This Conference is cosponsored by the American Dental Association (through the Council), the Centers for Disease Control and Prevention's Oral Health Program (CDC/OHP) and the National Institute of Dental Research (NIDR). A multidisciplinary national plan to significantly decrease morbidity and mortality related to oral and pharyngeal cancers is scheduled to be developed. Several Association agencies, including the Council, will be represented.

Next year the Council will be developing an action plan to respond to the Conference recommendations related to the prevention of oral cancer. As an interim step, during its March 1996 meeting, the Council reviewed the Association's existing policy statements on oral cancer prevention. The Council concluded that the two oral cancer policies adopted in the 1960s were outdated.

Therefore, the Council believes it necessary to rescind those existing Association policies and recommends adoption of the following resolution.

4. Resolved, that the American Dental Association, recognizing that early detection is critical for decreasing the morbidity and mortality associated with oral and pharyngeal cancer, encourages its members to promote early oral cancer detection through periodic extraoral and intraoral examinations, and be it further

Resolved, that the Association and constituent societies promote prevention and early detection of oral cancer through public education activities, and be it further

Resolved, that Resolution 32-1963-H (*Trans.*1963:287), Oral Cytology Programs, and Resolution 12-1967-H (*Trans.*1967: 290), Oral Cancer Detection Examinations, be rescinded.

National Health Objectives for the Year 2000: The Association has been an active member of the consortium of organizations participating in the development of the U.S Public Health Service's Healthy People 2000 National Health Promotion and Disease Prevention Objectives since 1987. The Council has been the focal point for this activity within the Association and remains committed to identifying opportunities through which organized dentistry can specifically impact the compendium of National Health Objectives, especially those related to oral health and tobacco.

Midcourse revisions were completed in all the Healthy People 2000 objectives during 1995 to allow for emerging science and new demographic data. In October 1995, Council staff attended the annual Healthy People 2000 Consortium meeting which focused on promoting "Healthy Cities/Healthy Communities" projects and coalition-building. The Healthy Cities/Healthy Communities model encourages citizens in the community, rather than health professionals, to determine their specific public health problem(s), assemble public/private coalitions, set goals and design program activities.

Support for States Without Public Health Dental Directors: The Council serves as a resource for state dental societies who wish to lobby for retention of or expansion of public health dental programs in their states. Budget reductions continue to downsize the number of state dental public health personnel and constrain program activity to the point where approximately one-quarter of state health department dental divisions are without the services of a full-time dental director.

Experiences in many states have shown that state dental associations are very influential in reestablishing and maintaining state dental director positions and dental public health programs. At its March 1996 meeting, the Council approved the distribution of a letter and fact sheet on the benefits of employing a full-time state public health dental director.

Response to Assignments from the 1995 House of Delegates

Amendment of ADA *Bylaws* Regarding Council Duties: Resolution 1H-1995 (*Trans.*1995:609) amended the Council's *Bylaws* duties. All pertinent documents have been modified to reflect the change.

Comprehensive Lists of State Programs Providing Oral Health Services: Resolution 2H-1995 (*Trans.*1995:609) encourages constituent and component dental societies to maintain comprehensive listings of the numerous and varied programs operating in each state that provide oral health services to underserved and unserved individuals. In April, the Council communicated this policy to both constituent and component dental societies.

Fluoridation Quality and Infrastructure: Resolution 3H-1995 (*Trans.*1995:609) supports actions to maintain the quality of national community water fluoridation and its infrastructure, including performance of infrastructure assessments by state health departments as needed; allocation of resources to appropriate state agencies to upgrade and maintain infrastructure; and observance of the Centers for Disease Control and Prevention's *Engineering and Administrative Recommendations for Water Fluoridation—1995* by fluoridation water systems in all states. As noted earlier in this report (page 35), in 1995 all state public health dental directors were made aware of the Association's new policy statement.

High Blood Pressure Education and Screening Program: Resolution 4H-1995 (*Trans.*1995:610) amends the Suggestions for Dentists on Participating in the National High Blood Pressure Education and Screening Program (*Trans.*1976:114,

848). As noted earlier in this report, Dr. Brodie Secrest, Jr., Council consultant, informed the National High Blood Pressure Education Program Coordinating Committee of the Association's revised policy during a March 1996 meeting (page 38).

Support for Programs that Forecast Public Demand for Dental Services: Resolution 16H-1995 (*Trans.*1995:609) was attached to an overall manpower report presented to the ADA House of Delegates. This report highlighted survey data regarding manpower issues in the profession. Resolution 16H, as adopted, emphasizes support for such forecasting. It has been communicated to the Association's Survey Center and may be used by Association agencies that communicate with state or national legislative bodies.

Modifications to the ADA Manpower Projection Model: Resolution 18H-1995 (*Trans.*1995:609) directs that the ADA Manpower Model assess the impact of aging populations, length of working life, foreign-trained practitioners, women and prevention in the construct of the model. This resolution has been forwarded to the ADA Survey Center to be used in its manpower modeling.

Investigating Practice Opportunities to Provide Care to Underserved Population Groups and in Nontraditional Settings: Resolution 19H-1995 (*Trans.*1995:624) directed appropriate Association agencies to investigate the development of resource materials to assist and encourage dentists who desire to provide needed care to underserved populations. The impetus for this idea came from the Council. The Council was interested in developing a resource that would provide valuable information to dentists who are interested in developing a practice in a nontraditional setting or expanding their existing practice into a nontraditional setting. The Council is collaborating with the Council on Dental Practice on this activity. The document, expected to be available by year-end through the Department of Salable Materials, will fulfill the intent of the resolution.

Inclusion of Basic Oral Health Education in Nondental Health Care Training Programs: Resolution 20H-1995 (*Trans.*1995:609) encourages inclusion of basic oral health education in nondental health care professional training programs. While emanating from a joint CDP/CAPIR report, CAPIR acted as the Association's primary agency to implement this resolution. The Council has initiated expanded liaison with national nondental health care professional organizations. The intent of Resolution 20H will be addressed through this liaison.

Prevention of Baby Bottle Tooth Decay: Resolution 63H-1995 (*Trans.*1995:632) encourages the appropriate Association agencies to develop formal policies, recommendations, programs and strategies aimed at preventing baby bottle tooth decay, including a physician awareness program. The Council's response to Resolution 63H is outlined on page 37 of this report.

Amendment of Policy on Orofacial Protectors: Resolution 80H-1995 (Trans.1995:613) amends the policy of the Association regarding orofacial protectors. The revised policy has been communicated to the appropriate sports groups, and revisions in appropriate Association documents have been made.

Nicotine as an Addictive Substance: Resolution 86H-1995 (*Trans.*1995:609) updated a 1993 policy statement (*Trans.*1992:600) to affirm nicotine (in place of *tobacco*) as an addictive drug, as well as to urge prompt enactment of legislation authorizing the Food and Drug Administration (FDA) to regulate tobacco products as nicotine delivery devices and/or drugs. The Council's response to Resolution 86H is outlined on page 38 of this report.

Increase Access to Care for Athletes Competing in the Special Olympics: Resolution 87H-1995 (*Trans.*1995:614) directs appropriate agencies of the Association to study and report to the Board of Trustees ways in which the Association could become more directly involved and or responsible for a dental program connected with the Special Olympics. Although the Council on Communications has primary responsibility for this resolution, CAPIR is collaborating on the study of this issue.

The Council Chairman invited Dr. Steven Perlman, founder of the Special Athletes/Special Smiles (SASS) program to present information on SASS at its August 1996 meeting.

Affiliation Agreement Between the American Dental Association and the National Foundation of Dentistry for the Handicapped: Resolution 135H-1995 (*Trans.*1995:614) encouraged the Board of Trustees to renew the affiliation agreement between the Association and the National Foundation of Dentistry for the Handicapped (NFDH) for a three-year term beginning on January 1, 1996. The Council prepared a report on the NFDH and the history of the affiliation agreement for consideration by the Board of Trustees at its December 1995 meeting. At that time, the Board considered the House of Delegates recommendation and voted to renew the affiliation agreement for one year.

Recommendation for Policy Rescissions: In response to Resolution 15H-1995 (*Trans.*1995:659), the Council has reviewed all pertinent policies seven years old or older. In addition to those policies rescinded by resolutions as proposed in this report, the Council has approved the rescission of the following seven policies. Review is continuing on those policies which the Council felt needed to be revised; these will be reported on in future annual reports.

Closed Chest Cardiac Resuscitation. The Council reviewed this policy (*Trans.*1964:275) and agreed that it has been superseded by Resolution 101H-1976 (*Trans.*1976:860), Training in Cardiopulmonary Resuscitation. Therefore, the Council recommends that the following resolution be adopted.

5. Resolved, that Resolution 20-1964-H (*Trans.*1964:275), Closed Chest Cardiac Resuscitation, be rescinded.

Plaque Control. The Council reviewed this policy (*Trans.*1972:669) and agreed that, while well intended, it is no longer an appropriate policy for the Association. Therefore, the Council recommends that the following resolution be adopted.

6. Resolved, that Resolution 53-1972-H (*Trans.*1972:669), Plaque Control, be rescinded.

Observance of United Nations International Year of the Child. The Council reviewed this policy (*Trans.*1977:905) and noted that it was a time-specific action which has served its intended purpose. Therefore, the Council recommends that the following resolution be adopted.

7. Resolved, that Resolution 87H-1977 (*Trans.*1977:905), Observance of United Nations International Year of the Child, be rescinded.

Formation of Denture Referral Service. The Council reviewed this policy (*Trans.*1978:531) and determined that the policy is outdated and should be rescinded. Therefore, the Council recommends that the following resolution be adopted.

8. Resolved, that Resolution 111H-1978 (*Trans.*1978:531), Formation of Denture Referral Service, be rescinded.

International Year of Disabled Persons. The Council reviewed this policy (*Trans.*1980:555) and noted that it is time-specific and does not need to be maintained as ongoing policy. Therefore, the Council recommends that the following resolution be adopted.

9. Resolved, that Resolution 34H-1980 (*Trans.*1980:555), International Year of Disabled Persons, be rescinded.

Continuation of Funding of the National Health Professions Placement Network. The Council reviewed this policy (*Trans.*1982:520) and noted that it called for the discontinuation of funding for the National Health Professions Placement Network. Since this has been accomplished, the Council recommends that the following resolution be adopted.

10. Resolved, that Resolution 102H-1982 (*Trans.*1982:520), Continuation of Funding of the National Health Professions Placement Network, be rescinded.

Liaison with the National Organization on Disability. The Council reviewed this policy (*Trans.*1983:544) concerning the World Program of Action and the Decade of Disabled Persons and agreed that it is time-specific and does not need to be maintained as ongoing policy. Therefore, the Council recommends that the following resolution be adopted.

11. Resolved, that Resolution 5H-1983 (*Trans.*1983:544), Liaison with the National Organization on Disability, be rescinded.

Summary of Resolutions

2. Resolved, that with respect to nutrition and oral health, the Association encourage dentists to maintain current knowledge of nutrition as it relates to general and oral health and disease, and be it further
Resolved, that the Association encourage dentists to effectively educate and counsel their patients about proper nutrition and oral health, including eating a well-balanced diet and limiting the number of between-meal snacks, and be it further
Resolved, that the Association encourage constituent and component dental societies to work with school officials to ensure that school food services, including vending services and school stores, provide nutritious food selections, and be it further
Resolved, that the Association oppose targeting children in the promotion and advertisement of foods low in nutritional value and high in cariogenic carbohydrates, and be it further
Resolved, that the Association encourage continued federal support for programs that provide nutrition services and education for infants, children, women and the elderly, and be it further
Resolved, that the Association encourage the appropriate government agencies to prevent the distribution of non-nutritious and highly cariogenic foodstuffs under federal nutrition service programs, and be it further
Resolved, that Resolution 27-1973-H (*Trans.*1973:659), Sale of Sugar-Rich Products in Schools; Resolution 28-1973-H (*Trans.*1973:660), Food Product Labeling; Resolution 56-1974-H (*Trans.*1974:687), Amendment to National School Lunch Act and Federal Food Stamp Program; Resolution 24H-1978 (*Trans.*1978:500), Statement on Advertising of Sugar-Rich Products to Children over Television; Resolution 129H-1978 (*Trans.*1978:510), Reference to Sugar Substances in School Textbooks; Resolution 98H-1979 (*Trans.*1979:625), Report to the House of Delegates of Task Force on the Prohibition of the Sale of Confections in Schools; and Resolution 8H-1983 (*Trans.*1983:544), American Dental Association Support of Child Nutrition Programs, be rescinded.

3. Resolved, that the American Dental Association encourage elementary and secondary schools to integrate current principles of oral health and disease prevention throughout their health education curricula to increase awareness and knowledge of oral health and to promote behaviors that reduce the risk of oral disease or injury, and be it further
Resolved, that constituent and component dental societies be encouraged to work with the appropriate health and education officials and agencies in their communities to achieve these goals, and be it further
Resolved, that Resolution 40-1960-H (*Trans.*1960:234), Health Education in School and College Curricula; Resolution 45-1971-H (*Trans.*1971:525), Prevention of Dental Disease; and Resolution 54-1972-H (*Trans.*1972:670), Prevention in School Curriculums, be rescinded.

4. Resolved, that the American Dental Association, recognizing that early detection is critical for decreasing the morbidity and mortality associated with oral and pharyngeal cancer, encourages its members to promote early oral cancer detection through periodic extraoral and intraoral examinations, and be it further

Resolved, that the Association and constituent societies promote prevention and early detection of oral cancer through public education activities, and be it further

Resolved, that Resolution 32-1963-H (*Trans.*1963:287), Oral Cytology Programs, and Resolution 12-1967-H (*Trans.*1967:290), Oral Cancer Detection Examinations, be rescinded.

5. Resolved, that Resolution 20-1964-H (*Trans.*1964:275), Closed Chest Cardiac Resuscitation, be rescinded.

6. Resolved, that Resolution 53-1972-H (*Trans.*1972:669), Plaque Control, be rescinded.

7. Resolved, that Resolution 87H-1977 (*Trans.*1977:905), Observance of United Nations International Year of the Child, be rescinded.

8. Resolved, that Resolution 111H-1978 (*Trans.*1978:531), Formation of Denture Referral Service, be rescinded.

9. Resolved, that Resolution 34H-1980 (*Trans.*1980:555), International Year of Disabled Persons, be rescinded.

10. Resolved, that Resolution 102H-1982 (*Trans.*1982:520), Continuation of Funding of the National Health Professions Placement Network, be rescinded.

11. Resolved, that Resolution 5H-1983 (*Trans.*1983:544), Liaison with the National Organization on Disability, be rescinded.

Council on Dental Benefit Programs

McNeil, Kevin J., Massachusetts, 1996, chairman
Perno, Joseph L., New Jersey, 1996, vice chairman
Bates, Bruce D., Minnesota, 1998
Brink, Justin L., California, 1997
Bruce, Steven M., Idaho, 1996
Burns, Dennis A., Ohio, 1999
Cohlmia, Ray, Oklahoma, 1998
DeRose, Francesca, Wisconsin, 1999
Johnson, Charles E., Illinois, 1997
Jones, T. Howard, Georgia, 1999
Mason, Craig A., Hawaii, 1999
Powell, William D., Tennessee, 1997
Schmitt, William D., Pennsylvania, 1996
Shapiro, Elizabeth A., Illinois, 1996, *ex officio**
Spencer, James E., New York, 1998
Vaclav, Michael D., Texas, 1997, *ad interim*
Webb, Leslie S., Jr., Virginia, 1998
Feldman, Marye C., director
Conway, Thomas E., manager
Ellek, Donalda, manager
Killam, Thomas D., manager
Wils, Wendy, director, Contract Analysis Service

Meetings: The Council on Dental Benefit Programs (CDBP) met on December 15-17, 1995 and April 12-14, 1996. A third meeting is scheduled for July 14, 1996, following the Dental Benefits Conference entitled "The Employer/Employee Part of the Equation." The Council's liaison from the Board of Trustees, Dr. David A. Whiston, Sixteenth District trustee, attended the December 1995 meeting.

The Chairman appointed four subcommittees of the Council to focus on major areas of activity. These subcommittees met as follows:

Purchaser Information Service	February 3-4, 1996 and April 11, 1996
Quality Assessment and Improvement	February 16-17, 1996
Taxation of Dental Benefits	February 24, 1996
Third-Party Issues	March 1-2, 1996

At the Council's meeting to be held in July 1996, invitations will be extended to representatives of national dental organizations and to third-party payer representatives to meet and discuss matters of mutual interest.

Personnel: At the December 1995 meeting, the Council again elected Dr. Joseph L. Perno as vice chairman for the 1995-96 year.

The close of the 1996 annual session brings to an end the terms of four valued members of the Council: Dr. Steven M. Bruce; Dr. William D. Schmitt; Dr. Kevin J. McNeil, who has served as Council chairman since 1994; and Dr. Joseph L. Perno, who has served as vice chairman of the Council since 1994. These members have made great contributions to the work of the CDBP and have given unselfishly of their time and energy on behalf of the profession. Their efforts are acknowledged by the Council with great appreciation.

The Council sadly reports that one of its valued staff members, Mr. Steven Brink, passed away in April 1996. Steven was the manager of the Purchaser Information Service and was responsible for promoting direct reimbursement. The Council wishes to recognize Steven's commitment and dedication. Mr. Thomas D. Killam assumed the duties of manager, Purchaser Information Service in June 1996.

The Strategic Plan of the American Dental Association: The Council on Dental Benefit Programs supports the following objectives:

Objective 1: Legislative and Regulatory Advocacy. A majority of the issues for which the Council is responsible result in policy recommendations that require legislative and regulatory action.

Objective 2: Association Program and Financial Plan. The Council's products and resource materials are designed to assist dentists to educate patients, thus positively contributing to the Association's visibility with the dental profession as a whole.

Objective 4: Access to Dental Care. The Council contributes to the Association's efforts in gaining patients access to care by working with government and private purchasers of care to design dental benefit plans that do not exclude categories of dental treatment nor include language that prohibits the patients from taking advantage of dental coverage.

* Standing Committee on the New Dentist member without the power to vote.

Objective 5: Education and Licensure. Through materials and presentations, the Council continues to educate dental students about the various types of dental plans that they can expect to encounter once they begin practice.

Objective 6: Professional Image. The Council develops policies regarding quality dental plans that have helped to enhance the image of dentistry as a leader and as a reliable, credible resource for governmental agencies, plan purchasers and standards development groups.

Objective 7: Dental Practice Success. The Council continually works to reduce the expensive, time-consuming and labor-intensive hassles confronting dental offices that must deal with third-party payers' diverse and often obsolete systems.

Objective 8: Research. The Council strives to gain access to dental treatment data with the ultimate objective being development of a dental database that will have a major impact on dental research and analysis.

Federal Programs: The Council continues to monitor the dental component of the Medicaid and Medicare programs and of the Military Dependents Dental Plan. With respect to the Council's efforts in Medicaid, the Council's annual survey of state dental programs in Medicaid was conducted again in 1995 and will also be conducted in 1996. The 1995 survey was divided into four sections targeting dental expenditures under the program, available dental services, program administration and Medicaid dental providers. The report of the survey of the dental component of state Medicaid programs is available from the Council upon request.

The results of the 1995 survey indicate that in 30 states, dental benefits are available to all eligible beneficiaries of Medicaid, adults and children; in 12 states, dental benefits are offered only to children under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. Of the 30 states which provide dental benefits to adults, 11 limit these benefits to emergency care, denture services or both.

Using a total of 44 state responses, nearly $1.7 billion was spent on dental claims under the Medicaid Program in fiscal year 1995. Including those states not reporting, this certainly represents an increase from fiscal 1994. According to survey results, there are approximately 47,000 dentists enrolled as providers in the Medicaid program.

The Council, in conjunction with other agencies of the Association, has also been monitoring changes in Medicaid programs as states develop and implement their own health system reforms. Several states have obtained waivers from the federal government to implement changes in their Medicaid programs.

The TRICARE (military dependents) dental plan has caused quite a bit of activity for the Council in 1995-96. United Concordia Companies, Inc. (UCCI), a for-profit subsidiary of Blue Shield of Pennsylvania, has been administering the plan since February 1996. The Council is currently working with UCCI to get it to utilize the *CDT-2* codes.

Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs): The Council continues to monitor the status and progress of the dental component of the HMO/PPO industry. The Council has compiled data from various sources to create an informational package of HMOs that offer some level of dental services as part of their programs. This revised compilation is available from the Council office upon request.

According to data available as of January 1996, there were 224 HMOs that offer some level of dental services. Of those, 104 are federally qualified. There were also 115 PPOs that offered some level of dental benefits. Many of the HMOs and PPOs offer dental coverage as part of their standard package while others offer dental coverage only as an option.

Of the total respondents to a recent survey conducted by the Group Health Association of America (GHAA), 74% of HMOs with plans over three years old cover dental/accidental injury. Forty-eight percent of those plans cover dental/accidental injury without limits or copayments. Thirty-nine percent of the respondents' plans cover temporomandibular joint treatment, 37% cover preventive dental care and 25% cover restorative dental care. Eighty-four percent of self-funded plans offer a dental component to their HMOs. The Council is paying special attention to any changes in these programs as they move into the health care marketplace in a more aggressive manner.

National Practitioner Data Bank: The Council continues to monitor the status of the National Practitioner Data Bank as it affects dental society peer review. Special attention is being directed to any possible changes in the Health Care Quality Improvement Act, especially with respect to the possibility of the Data Bank being opened up to the public.

The Council has also been made aware of the possibility of insurance companies purchasing Data Bank information from entities authorized to access the Data Bank. Association legal counsel is reviewing this matter with the Data Bank.

The Council has revised its booklet, *National Practitioner Data Bank: Questions and Answers,* which is available upon request by contacting the Council office.

Peer Review: The Council reviewed the statistics compiled from the 1995 National Peer Review Reporting System survey. The Council will again be conducting a peer review survey in 1996.

The Council is pleased to note that the number of cases that have been resolved at the mediation stage has increased over the past few years from 40% to 49%. Successfully mediated cases can save time and money, and can help to maintain the dentist-patient relationship.

The Council directed staff to check the availability of a fall 1997 date for a national conference on peer review. While the constituent societies believe the state workshops are beneficial, they would also like the opportunity for the exchange of ideas among their colleagues. A question will be added to the new peer review survey asking for interest in such a conference, and this information will be reported to the Council at its July 1996 meeting.

The Council discussed possible changes to the *Peer Review* manual. The Council recommended that if requested, state societies should be informed that each state develop its own definition of "gross negligence," develop its own appeals criteria for peer review and set term limits for members based on state bylaws and regulations.

The Council also discussed the issue of allowing for "damages" in the mediation stage of peer review. The Council recommended that this be done on a state-by-state basis.

Since 1989, the Council has sponsored several mediation training workshops conducted by professional mediators. In addition to the Council-sponsored workshops, the mediators have also been invited to conduct workshops for various state societies. Also, the Council has incorporated mediation skills development into its peer review assistance programs.

In 1996, the Council will be seeking outside funding to conduct additional mediation training workshops. Any meetings will be held at Association Headquarters in Chicago. Several states have sought alternative funding sources for their own mediation programs.

The Council discussed the current program schedule for the 1996 peer review assistance programs. All five budgeted workshops have already been scheduled. Workshops were held for the Virginia Dental Association and the Minnesota Dental Association. The Council has also confirmed workshops for the Arkansas State Dental Association, the New Mexico Dental Association and the Nebraska Dental Association.

As indicated, the new programs have incorporated mediation training skills and have available, upon request, an ethics component and a risk management component as they relate to dental society peer review. The Council has sent revisions for the peer review manual to the printer and has already revised the peer review brochure.

The Council has written protocols for the distribution of the peer review manual. The Council recommended that the peer review manual only be distributed to dental society staff and representatives, and that all other requests for the manual should be made in writing to the Council office for review on a case-by-case basis. Individuals requesting a peer review manual will first be directed to contact the state society where they will be going through peer review. This is because the state society manual would have precedence over the ADA manual.

Purchaser Information Service (PINSERV): The Service is established as the authority and primary resource for plan sponsors and patients in need of assistance in designing meaningful dental benefit plans. The goals of PINSERV are to:

1. promote direct reimbursement (DR) and other dental benefit plan models in accordance with the policies of the American Dental Association;
2. increase the number of individuals covered by dental benefit plans; and
3. improve currently existing dental benefit plans where the level of benefits and extent of coverage are less than optimal.

Direct Reimbursement. PINSERV continues to distribute direct reimbursement promotional materials to both the public and Association members at no charge. These informational materials are intended to educate interested parties about the DR concept and assist plan purchasers with implementing such plans.

As a result of the articles about DR which have appeared in every edition of the *ADA News* since January 1996, dentists have become very active promoters of the concept. They have become informed about DR and have been willing to discuss the concept with those patients who are involved in purchasing health benefits for their companies.

PINSERV continues to assist numerous constituent and component societies with DR promotion. Over two-thirds of all state societies distribute DR information to employers and Association members.

Last year, the Council proposed the development of a database that would contain a list of employers with DR plans in addition to information about their plan designs and plan experience.

The cost projection service provided by PINSERV to plan purchasers is being updated and will be available in early July 1996. At that time, the Council intends to hold a seminar for state and component dental society staff responsible for promoting DR so that they will have the capability of doing cost projections for the employers they contact.

In the past, the Council has promoted DR through advertising in specific national publications. However, with the passage of Resolution 129H-1995 (*Trans.*1995:621), the Council decided that, with the exception of *Employee Benefit News* placements, it would hold all advertising to be coordinated with the advertising to promote Resolution 129H-1995. A progress report from the Board of Trustees will be presented to the 1996 House of Delegates.

PINSERV offers, free of charge to plan purchasers, a dental plan review service. The Council provides a written review of any current or proposed dental plan submitted by the employer. The review is for the employer's internal use.

On July 11, 1996, the PINSERV and the Alliance for Dental Reimbursement Plans (ADRP) are jointly sponsoring a program (DR Day) for constituent and component dental society staff, interested dental leaders, insurance brokers and third-party administrators (TPAs). This program provides an opportunity to discuss what programs are in effect throughout the country, as well as to introduce attendees to new tools, such as computer programs for administering DR plans, potential health/swipe cards, etc. Many state societies have expressed an interest in offering TPA services to DR plan purchasers.

Exhibiting resource materials, services and information at human resources and benefits conventions continues to be an important activity for the Council. Preshow mailings and targeted advertising alert convention attendees to the presence of the PINSERV at these shows and allow the attendees to seek out the Council's booth for information and materials. Two additional exhibit booths are maintained and available for constituent and component dental societies to use to present dental benefit information at state and local employer meetings.

In addition to several presentations at dental society meetings, Council members and staff have given presentations at various meetings of employers and benefits managers. These presentations emphasize the differences between the provision and payment of dental and medical care. They also explain the consequences of various plan design deficiencies, including exclusions and limitations placed on treatment as well as restrictions on referrals.

Individual Practice Associations (IPAs). Many state and local societies have expressed an interest in developing IPAs and some have already established them. In 1997, the Council intends to conduct a survey of all known IPAs in order to build a database on types of plans offered, number of enrollees, effectiveness of the organizations, etc.

Coordination of Benefits: The 1994 House of Delegates referred Resolution 116 (*Trans.*1994:670), Guidelines on Coordination of Benefits for All Third-Party Payers, to the Council for study and report to the 1995 House. The resolution reads as follows:

> **116-1994. Resolved,** that the title of the current Guidelines on Coordination of Benefits (*Trans.*1991:635) be amended and changed to Guidelines on Coordination of Benefits for All Third-Party Payers, and be it further **Resolved,** that these Guidelines be amended by changing guideline 3.a. to read:
>
> > When the reduced-fee plan is primary, and treatment is provided by a participating dentist, the reduced-fee plan should provide its allowed amount for participating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan benefits and the dentist's full fee.

Resolution 116-1994 directed the Council to consider amending the current title of Guidelines on Coordination of Benefits to read Guidelines on Coordination of Benefits for All Third-Party Payers. In 1995 the Council rejected the change in the title because it did not believe the Association's policy should be limited to third-party payers. The Council believed the Guidelines should apply to plans that are self-administered by the plan sponsor as well as to fourth parties which are subcontractors hired by third parties to do dental claims processing.

In addition, Resolution 116-1994 directed that guideline 3a. be amended to permit dentists who participate in contractual arrangements for set reimbursements to bill the difference between their contractually agreed to reimbursements up to their usual fees when patients have secondary plans.

At the hearing of the 1995 Reference Committee on Dental Benefits, Practice and Health, the following concerns were expressed in relation to Resolution 116-1994:

1. it could place the Association in the position of interfering with a contractual agreement made between the dentist and a managed care organization;
2. third-party payers were selling secondary plans but patients are denied access to these benefits; and
3. the language would be illegal in some states.

Due to these concerns, the 1995 House of Delegates referred Resolution 116-1994 to the Council for appropriate review and consideration.

The Council believes that dentists in contractual arrangements should be allowed to bill up to their usual fees if the contract allows. The ADA's Contract Analysis Service recommends that dentists negotiate this matter with the payers, and this recommendation is now incorporated into the Council's proposed revised version of the Guidelines on Coordination of Benefits.

In addition, the Council has addressed the issues associated with secondary plans putting the burden on the payers to provide plan purchasers and patients with status reports regarding secondary plan reserves and claims paid. The Council agreed that patients and plan purchasers needed to be informed by the third-party payer regarding the benefits derived or not accessible from secondary plans.

The Council, therefore, recommends that the following resolution be adopted as a substitute for Resolution 116-1994.

12. Resolved, that the following Guidelines on Coordination of Benefits be adopted.

Guidelines on Coordination of Benefits

1. When a patient has coverage under two or more dental plans the following rules should apply:
   a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
   b. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the patient receives more than the total charges for the dental services received.
   c. The difference between the benefits payments that the secondary plan would have paid had it been the primary plan and the benefits that it actually paid or provided shall be recorded as a benefit reserve for the patient.
   d. The secondary plan will use the benefit reserve to pay up to 100% of the patient's covered expenses incurred during the claim determination period.
   e. At the end of each claim determination the secondary plan will provide the patient and plan purchaser with a status report of claims paid and the benefit reserve.
2. In determining order of payment for care, the following rules should apply:
   a. The plan covering the patient other than as a dependent is the primary plan.
   b. When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary.
   c. When a determination cannot be made in accordance with the above, the plan that has covered the patient for the longer time should be considered as primary.
   d. When one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.
3. In coordinating care with a dental plan which contractually reduces the fees for services which participating dentists accept as payment in full, the following rules should apply:
   a. When the reduced-fee plan is primary and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee unless the dentist has contractually arranged that the reduced-fee plan should provide its allowed amount for participating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee. The secondary plan should pay the

lesser of: its allowed benefit or the difference between the primary plan's benefit and the reduced fee.

b. When the reduced-fee plan is primary and treatment is provided by a nonparticipating dentist, the reduced-fee plan should provide its allowed amount for nonparticipating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee.

c. When a full-fee plan is primary and a reduced-fee plan is secondary, the full-fee plan should provide its allowed amount for the service and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee.

4. In coordinating care between an indemnity and a capitation dental plan, the following rules should apply:

a. When the capitation plan is primary, the capitation payments to the treating dentist remain the capitation plan's usual care. The indemnity plan should pay benefits for the patient's surcharges or copayments up to the indemnity plan's allowable benefit.

b. When the indemnity plan is primary, and treatment is received from a capitation-participating dentist, the indemnity plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation plan's allowable amount.

c. When the indemnity plan is primary, and treatment is received from a non-capitation-participating dentist, the indemnity plan should pay its allowable benefit. The capitation plan will pay care, in keeping with the capitation plan's allowed amount for treatment by nonparticipating dentists.

d. No dental plan should contractually direct a dentist to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.

and be it further

Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further

Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these rules to determine coordination of benefits, and be it further

Resolved, that Resolution 10H-1991 (*Trans.*1991:635), Guidelines on Coordination of Benefits, be rescinded.

Purchaser Contact Program: Resolution 134H-1995 (*Trans.*1995:506) directed the Association to initiate an active program of involvement with current sponsors of dental benefit programs.

The Council decided that, in 1996, it would concentrate on two categories of companies:

1. those with publicly stated commitments to quality of product and value of employees, and
2. those whose well-being is tied directly to the health of dental practices.

Additional information regarding the implementation of Resolution 134H-1995 will be provided in the Council's supplemental report.

Managed Care Organizations (MCOs)—Gag Clauses and Incentives: The Council had become extremely concerned with the potential harm to patients and dentists based on the contractual clauses in some dental provider agreements that limit or restrict doctor-patient discussion concerning treatment options not covered by the plan; the plan's limitations, restrictions or shortcomings; etc.

MCOs may compensate providers through financial incentives that limit the use of certain procedures and referrals to other providers. MCOs may also use bonuses that increase as the MCOs' expenditures for patient care decrease. MCOs may withhold a fixed percentage of a provider's income to cover any shortage in funds budgeted for care. At the end of the year, if there is little or no shortage, the remaining funds may be distributed to the participating providers.

The use of gag clauses and/or financial incentives by MCOs may present ethical, legal and business issues. Ultimately, their use may affect the care received by patients.

It is the Association's position that dentists who enter into managed care agreements may be called upon to reconcile the demands placed on them to contain costs with the oral health needs of the patient. The ADA's Council on Ethics, Bylaws and Judicial Affairs states that dentists must not allow these demands to interfere with the patient's right to select a treatment option based on informed consent. In other words, dentists are not excused from their ethical or legal obligations just because they have signed a contract.

The CDBP believes that full disclosure to subscribers by plan purchasers is essential for subscribers to make informed decisions regarding plan selection.

The Council agreed that policies on these important issues would enable the Association to take a leadership role in promoting legislation that will protect patients from undisclosed and potentially harmful strategies that are a part of managed care plans. The Council submitted three resolutions to the Board of Trustees with the request that the resolutions be adopted as interim policy of the Association. The three resolutions were adopted and will be reported to the House of Delegates in a separate Board Report.

Medically Necessary Care: The Council reviewed the issue of medically necessary care and recommends that two current Association policies on medically necessary care, Medically Necessary Adjunctive Care and Legislative Clarification of Language for Medically Necessary Adjunctive Care (*Trans.*1988:474), be amended by deleting the word *adjunctive* because of the adoption of a third policy, Definition of Medically Necessary Care (*Trans.*1990:537), which does not contain the word *adjunctive*.

Therefore, the Council recommends adoption of the following resolutions.

13. Resolved, that Resolution 36H-1988 (*Trans.*1988:474), Medically Necessary Adjunctive Care, be amended by deleting the word "adjunctive" in the first resolving clause so that the resolution reads as follows:

> **Resolved,** that the American Dental Association make every effort on behalf of patients to see that the language specifying treatment coverage in health insurance plans be clarified so that medically necessary care, essential to the successful treatment of a medical condition being treated by a multidisciplinary health care team, is available to the patient, and be it further
> **Resolved,** that when the ADA is notified of a situation in which a patient's treatment is jeopardized by the narrow interpretation of language contained in a medical benefit policy, the Association, with the assistance of its legal advisor, shall contact the plan purchaser directly in an effort to see that the employer's intentions regarding the benefit purchased for the employee are conveyed to the third-party payer.

14. Resolved, that Resolution 37H-1988 (*Trans.*1988:474), Legislative Clarification of Language for Medically Necessary Adjunctive Care, be amended by deleting the word "adjunctive" wherever it appears so that the resolution reads as follows:

> **Resolved,** that constituent dental societies be encouraged to pursue legislation or regulation at the state level to have the language in health benefit plans clarified so that medically necessary care is a required extension of covered medical procedures, and be it further
> **Resolved,** that the appropriate Association agencies seek federal legislative or regulatory actions to have the language in health benefit programs clarified so that medically necessary care is a required extension of covered medical procedures.

Definition of Dental Care: Resolution 59-1995 (*Trans.*1995: 618) was submitted to the 1995 House of Delegates by the Council. There was some discussion at the Reference Committee hearing as to whether the list of dental categories included in Resolution 59-1995 was the best type of definition of dental care. One member felt that a broad statement, omitting treatment categories altogether, would be better. Resolution 59-1995 was referred back to the Council for study.

After due consideration, the Council agreed that arguments could be made for both approaches to defining dental care. Various entities turn to the Association for guidance in this area. A nonspecific policy could have the definition of dental care open to misinterpretation and abuse. For instance, plan purchasers may quite unknowingly omit categories of dental treatment from their dental plans. Conversely, a broad statement could be interpreted to include hair analysis as an integral component of dental care. Therefore, the Council recommends that Resolution 59-1995 be adopted.

59-1995. Resolved, that the following definition of dental care be adopted.

> Dental care comprises diagnostic, preventive, restorative, oral and maxillofacial surgical, endodontic, orthodontic, periodontic, prosthodontic and aesthetic (cosmetic) services provided to dental patients by a legally qualified dentist or physician operating within the scope of his or her training.

Other Third-Party Issues: The Council recommended that a list of outside agencies be invited to a coalition meeting at the Association's Headquarters regarding health care fraud. The Council will monitor interest in the project.

Also, the Council is currently reviewing the issue of composite resin restorations in stress bearing areas and is working with the Council on Scientific Affairs to resolve this issue.

The Council will begin its revision of *CDT-2* in 1996. The Council members of the Advisory Committee on the *Code* will meet in June to begin revision of the glossary of terms, and the full Advisory Committee on the *Code* will meet in October to review code requests that have been submitted.

Taxation of Dental Benefits: Members of the Councils on Dental Benefit Programs, Dental Practice, and Governmental Affairs and Federal Dental Services met in February as the Subcommittee on Taxation of Dental Benefits, which was formed by the CDBP in response to Resolution 95H-1995 (*Trans.*1995:610). The resolution reads as follows:

> **Resolved,** that the American Dental Association review its policy opposing the taxation of dental benefits to employees or the loss of tax deductibility of the costs of dental benefit plans to purchasers, and be it further
> **Resolved,** that this review should weigh the economic impact of this change of policy on practicing dentists versus the health benefit of returning the responsibility of dental care to the patient and the elimination of any interference by outside agencies in the doctor-patient relationship, and be it further
> **Resolved,** that a report and resolution be submitted to the 1996 House of Delegates.

In addition to reviewing several articles regarding taxation of health benefits, the Subcommittee also reviewed current Association policy on Taxes on Health Care Services (*Trans.*1982:549), which reads as follows:

> **Resolved,** that the American Dental Association, for the good and welfare of the public, go on record as being opposed to all forms of taxes on health care services including employer-paid health fringe benefits.

The Subcommittee also reviewed the policy on Tax Deductibility of Dental and Medical Expenses (*Trans.*1989:548), which reads as follows:

> **Resolved,** that all costs incurred by an individual for the dental and medical expenses of the individual and his or her dependents should be tax-deductible without regard to adjusted gross income.

Dr. L. Jackson Brown, National Institute of Dental Research, presented a discussion of his Microsimulation Economic Model which was reported on in *JADA* Vol. 126,

April 1995. Dr. Brown's report is entitled *Effects of Changes in Dental Insurance on the Dental Sector*. Dr. Brown concluded that:

- reduction in dental insurance coverage will reduce dental expenditures;
- the reduction will be smaller than some have predicted;
- the impact on dentists will not be pleasant, but will also not be devastating;
- dentists with large percentages of patients with insurance will experience a greater impact than dentists with few insured patients;
- a sudden 75% reduction in the percent of dental expenditures paid by insurance would reduce the average yearly gross billings of dentists by $15,000-$18,000; and
- over time, market adjustments will reduce the initial impact of a sudden change and accommodate the effect of a gradual change.

The Council discussed the issue of taxation in the context of:

1. access to care;
2. dental health of the public;
3. credibility of the ADA; and
4. income of the dentist

when considering development of a new policy.

Based on the Subcommittee's review, the Council recommends that the Association's policy opposing taxation of dental benefits not be changed. No new policy is recommended at this time. The taxation issue will be reviewed by the appropriate agencies on an annual basis.

Diagnostic Coding: The Council's Advisory Committee on Dental Electronic Nomenclature, Indexing and Classification (ACODENIC) met in February 1996 at Association Headquarters to complete several tasks.

The ACODENIC started a project to review a comprehensive glossary of dental terms. This glossary will be a compilation of all glossaries submitted to the Association by various related organizations. The Council directed that the glossary be coordinated with the National Library of Medicine so that the glossary would fit into the Unified Medical Language System.

Dr. David Rothwell, of Systemized Nomenclature of Medicine (SNOMED International), has been mapping known dental terminology to the SNOMED system. The ADA will begin mapping in the near future.

Dental Practice Parameters: The Dental Practice Parameters Committee focused its activity on developing parameters and planning for the maintenance of parameters documents. Ten additional parameters were developed and will be submitted to the 1996 House of Delegates in a supplemental report. The ten parameters developed in 1996, along with those that were adopted by the House of Delegates in 1994 (*Trans.*1994:661-663) and 1995 (*Trans.*1995:615), represent the primary body of dental practice parameters developed by the American Dental Association.

The Dental Practice Parameters Committee (DPPC) discussed Resolution 147-1995 (*Trans.*1995:661) and determined that its directive would become a part of the DPPC's ongoing responsibility to monitor parameters of other health disciplines as they apply to dentistry. It is expected that, as the core parameters development phase gives way to the maintenance and revision phases of the parameters project, more defined processes for the use and application of parameters from other health disciplines will be developed.

Quality Assessment and Improvement: The Council is aware that accrediting bodies for managed care organizations plan to develop quality of care audit criteria (indicators of care) for oral health care. The Council believes that such criteria must be valid measures of the quality of oral health care and that the dental profession should participate in the development of the criteria. As a proactive position, the Council recommended that dental indicators of care should be developed by the Association, independently of accrediting bodies. Also, the Council recommended that the Association continue to monitor the activities of accrediting bodies and advocate the position of the profession, as necessary.

The Council has noted it has major responsibility for guiding quality assessment and improvement policy and activities, and that it has responsibility and authority for the Office of Quality Assessment and Improvement. The Council thus requests that such responsibility and authority be reflected in the *Bylaws*, describing the Council's scope of responsibility.

The Council, therefore, recommends adoption of the following resolution.

15. Resolved, that the Association's *Bylaws*, Chapter X, Section 110. DUTIES, Subsection D. COUNCIL ON DENTAL BENEFIT PROGRAMS, be amended by adding a new paragraph "f" to read as follows:

> f. To conduct activities and formulate and recommend policies relating to all matters involving the assessment and assurance of the quality of dental care, including those activities involving dental benefits plans.

Contract Analysis Service: Since its inception in 1987, the Contract Analysis Service has received over 2,400 contracts and has analyzed over 2,180 contracts. In 1995 the Service received 540 contracts; 486 were analyzed.

The Service continues to be a highly popular benefit as is evidenced by the large number of requests received each month. Most requests come from constituent societies on behalf of their members.

Member dentists may submit requests via their state or local dental societies or directly to the Association. In January 1993, a $50 charge was instituted to members requesting an analysis directly from the Association. As expected, most members submit their requests through the state and local societies and avoid the $50 charge.

In 1996, the Service participated in Association efforts to inform members about managed care issues. It has provided input for and prepared managed care articles. In addition, it continues to receive several requests each week for the informative handout "What Every Dentist Should Know Before Signing a Provider Agreement." The Service will continue to enhance these efforts.

For 1996, the Service has scheduled contract analysis presentations to the Illinois State Dental Society and the American Association of Oral and Maxillofacial Surgeons. In

addition, it is scheduled to make presentations at several American Dental Association managed care seminars.

In 1995, the Service established the following strategies:

1. to continue to eliminate the backlog and to meet current demand;
2. to continue to revise and prepare new informational material regarding dental provider contracts;
3. to work closely with the state and local societies to address member dental provider contracting concerns; and
4. to schedule between six and ten contract analysis presentations.

Response to Assignments from the 1995 House of Delegates

Statement on Managed Care and Utilization Management: Resolution 5H-1995 (*Trans.*1995:624) has been included in the Council's *1996 Policies on Dental Benefit Programs* and has been distributed to third-party payers and the National Association of Insurance Commissioners.

Statement on Quality Health Care: Resolution 6H-1995 (*Trans.*1995:609) has been included in the *1996 Policies on Dental Benefit Programs* and will be included in CDBP brochures as they are developed, revised and reprinted.

Parameters Resolutions: The following parameters documents, approved through the adoption of Resolutions 22H-1995 through 32H-1995 and 34H-1995 (*Trans.*1995:615), were distributed to all Association members.

- Dental Attrition;
- Dental Abrasion;
- Dental Erosion;
- Orofacial Soft Tissue Lesion(s);
- Patients With Orofacial Aesthetic Concerns;
- Gingival Recession (Marginal Tissue Recession);
- Malocclusion;
- Impacted/Unerupted Tooth;
- Pulpitis;
- Restoration(s) Needing Replacement or Modification;
- Pericoronitis; and
- Traumatically Displaced Tooth.

Resolution 33-1995, Temporomandibular (Craniomandibular) Disorders (*Trans.*1995:615), was referred back to the Dental Practice Parameters Committee. It is in the process of being revised and will be resubmitted to the 1996 House in a supplemental report.

Amendment to the Guidelines on the Use of Radiographs in Dental Care Programs: Resolution 56H-1995 (*Trans.*1995:617) has been included in the Council's *1996 Policies on Dental Benefits Programs* and has been distributed to third-party payers.

Requirements for Managed Dental Care Programs: Resolution 57H-1995 (*Trans.*1995:627) has been included in the Council's *1996 Policies on Dental Benefits Programs* and has been distributed to third-party payers and plan purchasers.

Explanation of Dental Reimbursement Mechanisms: Resolution 58H-1995 (*Trans.*1995:609) is still under review by the Council. A document to be entitled The ADA's Glossary of Dental Benefit Terms will be submitted to the 1996 House in a supplemental report.

Development of Standards for Insurance Company Communications: The Council is implementing Resolution 61H-1995 (*Trans.*1995:609) through the American National Standards Institute, Standard 835—Claims Payment, as well as through the National Association of Insurance Commissioners. It will also be discussed with the Dental Relations Subcommittee of the Health Insurance Association of America.

Information on Calculation of Benefits: A response to Resolution 74-1995 (*Trans.*1995:648) will be reported to the 1996 House of Delegates in a supplemental report.

Review of Association's Policy on Taxation of Dental Benefits: Council consideration of Resolution 95H-1995 (*Trans.*1995:610) is contained in the section of this report entitled Taxation of Dental Benefits (see page 48).

Opposition to Dental Benefit Plans or Programs Conflicting with ADA Policies: Resolution 96H-1995 (*Trans.*1995:620) has been included in the Council's *1996 Policies on Dental Benefit Programs*.

Amendment to the Guidelines for Dental Components of Health Maintenance Organizations: Resolution 97H-1995 (*Trans.*1995:610) has been included in the Council's *1996 Policies on Dental Benefit Programs*.

Development of Diagnostic Coding: Resolution 111H-1995 (*Trans.*1995:619) has been made an integral part of the Council's work in developing a diagnostic coding system for dentistry. Reports on the progress of this project are regularly made to the Board of Trustees.

Language in Explanation of Benefit Forms: Resolution 124H-1995 (*Trans.*1995:610) has been included in the Council's *1996 Policies on Dental Benefit Programs* and will be discussed with third-party payers.

Submission of Electronic Dental Claims: Resolution 132H-1995 (*Trans.*1995:623) has been included in the Council's *1996 Policies on Dental Benefit Programs* and will be acted upon with the appropriate entities.

Purchaser Contact Program: A report on Resolution 134H-1995 (*Trans.*1995:610) is included in this report under the section entitled Purchaser Contact Program (see page 47).

Interdisciplinary Practice Parameters: A report on Resolution 147-1995 (*Trans.*1995:661) is included in this report under the section entitled Dental Practice Parameters (see page 49).

Guidelines on Coordination of Benefits for All Third-Party Payers: Resolution 116-1994 (*Trans.*1994:670;1995:618) is discussed in this report under the section entitled Purchaser Information Service (see page 46).

Identification of Claims Reviewers on Explanation of Benefit Statements: Resolution 119-1994H(1995) (Trans.1995:610) has been included in the Council's *1996 Policies on Dental Benefit Programs* and distributed to third-party payers.

Summary of Resolutions

12. Resolved, that the following Guidelines on Coordination of Benefits be adopted.

Guidelines on Coordination of Benefits

1. When a patient has coverage under two or more dental plans the following rules should apply:

   a. The coverage from those plans should be coordinated so that the patient receives the maximum allowable benefit from each plan.
   b. The aggregate benefit should be more than that offered by any of the plans individually, but not such that the patient receives more than the total charges for the dental services received.
   c. The difference between the benefits payments that the secondary plan would have paid had it been the primary plan and the benefits that it actually paid or provided shall be recorded as a benefit reserve for the patient.
   d. The secondary plan will use the benefit reserve to pay up to 100% of the patient's covered expenses incurred during the claim determination period.
   e. At the end of each claim determination the secondary plan will provide the patient and plan purchaser with a status report of claims paid and the benefit reserve.

2. In determining order of payment for care, the following rules should apply:

   a. The plan covering the patient other than as a dependent is the primary plan.
   b. When both plans cover the patient as a dependent child, the plan of the parent whose birthday occurs first in a calendar year should be considered as primary.
   c. When a determination cannot be made in accordance with the above, the plan that has covered the patient for the longer time should be considered as primary.
   d. When one of the plans is a medical plan and the other is a dental plan, and a determination cannot be made in accordance with the above, the medical plan should be considered as primary.

3. In coordinating care with a dental plan which contractually reduces the fees for services which participating dentists accept as payment in full, the following rules should apply:

   a. When the reduced-fee plan is primary and treatment is provided by a participating dentist, the reduced fee is that dentist's full fee unless the dentist has contractually arranged that the reduced-fee plan should provide its allowed amount for participating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee. The secondary plan should pay the lesser of: its allowed benefit or the difference between the primary plan's benefit and the reduced fee.
   b. When the reduced-fee plan is primary and treatment is provided by a nonparticipating dentist, the reduced-fee plan should provide its allowed amount for nonparticipating dentists and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee.
   c. When a full-fee plan is primary and a reduced-fee plan is secondary, the full-fee plan should provide its allowed amount for the service and the secondary plan should pay the lesser of: its allowed benefit for the service or the difference between the primary plan care and the dentist's full fee.

4. In coordinating care between an indemnity and a capitation dental plan, the following rules should apply:

   a. When the capitation plan is primary, the capitation payments to the treating dentist remain the capitation plan's usual care. The indemnity plan should pay benefits for the patient's surcharges or copayments up to the indemnity plan's allowable benefit.
   b. When the indemnity plan is primary, and treatment is received from a capitation-participating dentist, the indemnity plan should pay its allowable benefit. The capitation payments to the dentist are the secondary coverage since they constitute care up to the capitation plan's allowable amount.
   c. When the indemnity plan is primary, and treatment is received from a non-capitation-participating dentist, the indemnity plan should pay its allowable benefit. The capitation plan will pay care, in keeping with the capitation plan's allowed amount for treatment by nonparticipating dentists.
   d. No dental plan should contractually direct a dentist to charge a secondary carrier for more than the amount which would be charged to the patient absent secondary coverage.

and be it further
Resolved, that third-party payers, representing self-funded as well as insured plans, should be urged to adopt these guidelines as an industry-wide standard for coordination of benefits, and be it further
Resolved, that constituent societies are encouraged to seek enactment of legislation that would require all policies and contracts that provide benefits for dental care to use these rules to determine coordination of benefits, and be it further
Resolved, that Resolution 10H-1991 (*Trans.*1991:635), Guidelines on Coordination of Benefits, be rescinded.

13. Resolved, that Resolution 36H-1988 (*Trans.*1988:474), Medically Necessary Adjunctive Care, be amended by deleting the word "adjunctive" in the first resolving clause so that the resolution reads as follows:

Resolved, that the American Dental Association make every effort on behalf of patients to see that the language specifying treatment coverage in health insurance plans be clarified so that medically necessary care, essential to the successful treatment of a medical condition being treated by a multidisciplinary health care team, is available to the patient, and be it further

Resolved, that when the ADA is notified of a situation in which a patient's treatment is jeopardized by the narrow interpretation of language contained in a medical benefit policy, the Association, with the assistance of its legal advisor, shall contact the plan purchaser directly in an effort to see that the employer's intentions regarding the benefit purchased for the employee are conveyed to the third-party payer.

14. Resolved, that Resolution 37H-1988 (*Trans.*1988:474), Legislative Clarification of Language for Medically Necessary Adjunctive Care, be amended by deleting the word "adjunctive" wherever it appears so that the resolution reads as follows:

Resolved, that constituent dental societies be encouraged to pursue legislation or regulation at the state level to have the language in health benefit plans clarified so that medically necessary care is a required extension of covered medical procedures, and be it further

Resolved, that the appropriate Association agencies seek federal legislative or regulatory actions to have the language in health benefit programs clarified so that medically necessary care is a required extension of covered medical procedures.

15. Resolved, that the Association's *Bylaws*, Chapter X, Section 110. DUTIES, Subsection D. COUNCIL ON DENTAL BENEFIT PROGRAMS, be amended by adding a new paragraph "f" to read as follows:

f. To conduct activities and formulate and recommend policies relating to all matters involving the assessment and assurance of the quality of dental care, including those activities involving dental benefits plans.

59-1995. Resolved, that the following definition of dental care be adopted.

Dental care comprises diagnostic, preventive, restorative, oral and maxillofacial surgical, endodontic, orthodontic, periodontic, prosthodontic and aesthetic (cosmetic) services provided to dental patients by a legally qualified dentist or physician operating within the scope of his or her training.

Council on Dental Practice

Kiesling, Roger K., Montana, 1996, chairman
Aurbach, Frederick E., Texas, 1997, vice chairman
Carrier, Gerald R., Massachusetts, 1997
Cohen, Paul D., Washington, D.C., 1997
Elliott, Anita, Arizona, 1996, *ex officio**
Kaczkowski, Stanley W., West Virginia, 1996
Lau, Calvin S., California, 1996
Norman, Charles H., North Carolina, 1999
Ragan, Robert T., Mississippi, 1998
Raibley, Bruce D., Indiana, 1999
Rundle, James F., Iowa, 1996
Selcher, Samuel E., Pennsylvania, 1997
Sherwood, Cynthia E., Kansas, 1999
Sherwood, Richard, New York, 1998
Smith, A. J., Utah, 1998
Suchy, Keith W., Illinois, 1999
Werschky, Jay A., Michigan, 1998
Bramson, James B., director
Collins, Donald, manager
Crosby, Linda R., manager
Gleason, Colleen M., manager
Magnuson, Lisa M., manager
Noskin, Diane E., manager

Meetings: The Council on Dental Practice (CDP) met in the Headquarters Building on November 16-18, 1995 and May 16-18, 1996. Dr. Richard Mascola, Second District trustee, serves as the Board of Trustees' liaison to the Council.

Organization: The Council is organized into two subcommittees to facilitate its work activities. These subcommittees are the Subcommittee on Dental Team Members and Practice Management Publications (Committee A) and the Subcommittee on Special Projects (Committee B). The subcommittees met in conjunction with regularly scheduled Council meetings immediately prior to the plenary sessions.

Personnel: At the December meeting of the Council, Dr. Fred Aurbach was unanimously elected vice chairman for 1995-96. The 1996 annual session will mark the retirement of Dr. Stanley Kaczkowski, Dr. Roger Kiesling, Dr. Calvin Lau and Dr. James Rundle. The Council wishes to express its appreciation to these individuals for their thoughtful, determined leadership and for the many contributions during their tenure.

The Strategic Plan of the American Dental Association: The Council's activities relate to ADA Strategic Plan Guiding Principles 1, 3 and 5 as well as the following specific objectives.

Objective 1: Legislative and Regulatory Advocacy. The Council regularly assists with testimony or policy recommendations that affect legislative or regulatory actions, in turn affecting the dental office environment.

Objective 2: Association Program and Financial Plan. The Council's products and resource materials assist dentists in learning more about various practice configurations. Products are developed and sold by the Department of Salable Materials, contributing to the overall nondues revenue of the ADA.

Objective 3: Membership Recruitment and Retention. The Council developed tangible products and material resources such as guidelines, reports, publications, seminars and other educational products, illustrating the value of membership.

Objective 6: Professional Image. The Council's activities seek to promote greater use of practice management skills and the team concept. This, in turn, promotes a positive professional image. Moreover, issues of impaired professionals will ultimately reflect upon the entire profession.

Objective 7: Dental Practice Income. The Council continually inspects practice management data and resources to help dentists become more effective and efficient business people. This has been especially prevalent with issues of managed care marketplace and practice economics.

Objective 10: Associated Organizations. The Council conducts liaison efforts with organizations that represent dental assistants, dental hygienists and dental laboratory technicians. These relationships assist the Council in investigating the scope and complexity of issues of the dental team members.

* Standing Committee on the New Dentist member without the power to vote.

Objective 11: Dental Team. A major CDP interest is in promoting and developing programs to assist dentists in fostering a unified and productive dental team. Through these efforts, the Council seeks to identify cooperative projects that improve the in-office team atmosphere.

Response to Assignments from the 1995 House of Delegates

Amendment of ADA Policy Statement on Prosthetic Care and Dental Laboratories: Resolution 7H-1995 (*Trans.*1995:623) directed changes in the Statement on Prosthetic Care and Dental Laboratories. Specifically, it made amendments to the sections that deal with shade selection. New language clarifying that delegation of shade selection to a dental laboratory technician should be at the professional judgment of the dentist. This amended policy statement has been forwarded to appropriate organizations, including the National Association of Dental Laboratories (NADL).

Support for Programs that Forecast Public Demand for Dental Services: Resolution 16H-1995 (*Trans.*1995:609) was attached to an overall manpower report presented to the 1995 House of Delegates (*Supplement* 1995:301). This report highlighted survey data regarding manpower issues in the profession. Resolution 16H-1995, as adopted, emphasizes support for such forecasting. It has been communicated to the Association's Survey Center and shall be used by Association agencies that communicate with state or national legislative bodies.

Measuring the Demand for Dental Services: Resolution 17H-1995 (*Trans.*1995:623) is concerned with external and internal research projects that attempt to forecast service capacity levels in dentistry. The resolution directs that measures of capacity take into account individual variations in practice style, specialty, office preference, location and demand for services.

CDP used this resolution as part of the philosophical basis for its *Financial Impact Analysis of Plan Contracts* economic worksheet. No imputed capacity measures were used in the construction of the model. Rather, the individual practitioner can define his or her own busyness and inherent capacity to determine if participation in a plan is desired.

Modifications to the ADA Manpower Projection Model: Resolution 18H-1995 (*Trans.*1995:609) directs that the ADA Manpower Model assess the impact of aging populations, length of working life, foreign-trained practitioners, women and prevention in the construct of the model. This resolution has been forwarded to the ADA Survey Center to be used in its manpower modeling.

Investigating Practice Opportunities to Provide Care to Underserved Population Groups and in Nontraditional Settings: Resolution 19H-1995 (*Trans.*1995:624) directed investigation of resource material to assist in helping practitioners provide care to underserved populations, most notably, institutionalized patients. The impetus for this idea came from the Council on Access, Prevention and Interprofessional Relations (CAPIR). CDP is collaborating with CAPIR to develop a resource for member dentists interested in developing and marketing a dental practice in a nontraditional setting. The resource, expected to be available by year-end through the Department of Salable Materials, will fulfill the intent of this resolution.

Inclusion of Basic Oral Health Education in Nondental Health Care Training Programs: Resolution 20H-1995 (*Trans.*1995:609) encourages inclusion of basic oral health education in nondental health care professional training programs. This resolution emanated from a joint CDP/CAPIR report; CAPIR acted as the Association's primary agency to implement this resolution. CAPIR has initiated expanded liaison with national nondental health care professional associations. The intent of Resolution 20H will be addressed through this liaison.

Vision of Dentistry's Future: Resolution 66-1995 (*Trans.*1995:610) was considered by the House of Delegates and referred to CDP for study. This resolution sought to conduct a forum or workshop, if feasible, to comment on the vision for dentistry's future. CDP considered this resolution at its November 1995 meeting and discussed its meaning and intent. It was determined that a much broader agency discussion of this resolution was needed before any recommendations could be determined. As a result, CDP was granted funding by the ADA Board of Trustees to hold a one-day meeting of representatives of CDP and the Council on Dental Benefit Programs (CDBP), the Council on Dental Education (CDE), the Council on Ethics, Bylaws and Judicial Affairs (CEBJA) and the Committee on the New Dentist (CND).

A meeting of this group was held on April 11, 1996. Representatives in attendance were Dr. Paul Cohen, chairman, and Dr. Cynthia Sherwood, CDP; Dr. Craig Mason and Dr. Dennis Burns, CDBP; Dr. Rowland Hutchinson, CDE; Dr. Gerry Kaufman, CEBJA; and Dr. James Cantwil, CND. The group reviewed and discussed material from several Association activities including the ongoing Institute of Medicine (IOM) Task Force, the ADA Strategic Planning Committee and the Association's Critical Issues Task Force in an attempt to determine if additional activity is to be recommended. A report of the group was forwarded to the CDP at its May 1996 meeting.

The Council recognizes the importance of developing a vision for the future of dentistry that should include input from private practice, academia and institutional representatives of the profession. The Council believes that this effort would be best organized under the ongoing work of the ADA Strategic Planning Committee (SPC), coordinated through the office of the Executive Director. The Council offered its private practice expertise and the summary information it gathered from the group meeting to SPC as assistance as it believes this group discussion would be beneficial to SPC. CDP also would be pleased to act as a consultant to SPC, or in whatever capacity it deems most appropriate.

Development of Financial Planning Publication for Dental Students: Resolution 108-1995 (*Trans.*1995:644), which was referred to the Council on Membership (CM), sought to develop resource material for students regarding financial planning and cash flow strategies. CDP has much current resource material contained in several of its publications in the Practice Management Series, as well as the SUCCESS

materials. As a result, CDP offered to assist the CM with this publication.

CDP developed a draft manuscript which highlighted cash flow, credit reporting and time value of money. This material was developed for a multipanel brochure since a more extensive resource would duplicate existing materials. Several Association agencies are reviewing the manuscript and publication is planned before year-end.

Council Activities

SUCCESS 1995-96: Completing its thirteenth successful year of operation, the SUCCESS Program has continued to grow in both popularity and impact. In 1991, the Program was retitled SUCCESS to more accurately reflect the current content of the Program. Formerly known as OPTIONS, the Program concentrates on the items and issues that a pending graduate would face as he or she enters private practice. Response from corporate sponsors, dental students, dental schools and organized dentistry continues to be extremely positive. Senior dental students throughout the United States benefited from the efforts of SUCCESS 1995-96. Representatives of the American Student Dental Association (ASDA) were involved in promoting student attendance at the seminar in their respective schools and assisted in the distribution of materials at the seminar site. This has proven to be a tangible benefit of organized dentistry and is enhancing both ASDA's and the Association's image among students and faculty.

SUCCESS 1995-96 continued to focus upon the business needs and concerns of junior and senior dental students approaching graduation and faced with career and business decisions. The Program conveyed this information to the students in two ways: First, the Association's publication, *The Successful Dental Practice: An Introduction*, was distributed to approximately 4,200 senior dental students. This comprehensive 120-page manual includes chapters on choosing a practice location, buying a practice, dental office design, office staffing, records systems, benefit plans, insurance for the dentist and several other sections on office practice management. Corporate sponsorship was appropriately recognized in this publication.

Second, a one-day practice management seminar, "Starting Your Dental Practice," was scheduled at 28 dental school campuses in 1995-96. This concentrated seminar covers such topics as management decisions, practice leadership, locating a practice, purchase of a practice, personnel and staffing decisions, office communications, the cost of doing business, insurance processing, billing and collections, appointment scheduling, alternative reimbursement plans and marketing strategies. A comprehensive seminar manual was distributed to all seminar attendees to use as an ongoing reference and as a gift from the corporate sponsors and organized dentistry.

Corporate Sponsors. The following corporate sponsors contributed the resources to conduct the Program: 3M Dental Products; ADA, Mellon and Dreyfus; A-dec, Inc.; Colgate-Palmolive Company; DENTSPLY International; Eastman Kodak Company; The Equitable Life Assurance Society of the United States, New York, NY; Great-West Life & Annuity Insurance Company; Henry Schein, Inc.; Procter & Gamble Company; Ultradent Products, Inc.; and the Warner-Lambert Company.

It should be noted that several of the above sponsors have been supportive of the SUCCESS Program since its inception in 1983. The American Dental Association is appreciative of their generous involvement on behalf of organized dentistry.

Sponsor Recognition. Corporate sponsors received the following benefits and recognition: a feature article in the September 4, 1995 issue of the *ADA News* distributed to approximately 140,000 dentists and subscribers; an article in the October 1995 *ASDA News* distributed to 12,740 dental and post-doctoral students; formal acknowledgment on the inside front cover of the publication, *The Successful Dental Practice: An Introduction*, distributed to senior dental students; acknowledgment on the inside front cover of the seminar manual, *Starting Your Dental Practice*, distributed to the junior and senior dental students participating in the seminar; distribution of sponsor literature to all seminar participants via a dossier in which interested corporate sponsors placed a promotional flyer, usually with a business reply card; opportunities for sponsors to send representatives to student seminars; labels for direct mail purposes of student attendees who complete the practice management publication coupon; and a formal plaque in recognition by the Association.

Seminar Site Selection. SUCCESS 1995-96 seminars were presented on the dates indicated below (the first school listed after each date is the seminar site and students from the listed neighboring schools were also invited): September 12, University of Iowa College of Dentistry; September 14, Louisiana State University; September 29, Ohio State University; October 14, University of Michigan/University of Detroit; October 17, University of Alabama; October 19, Baylor College of Dentists; October 20, University of Texas Health Science Center at San Antonio; October 21, University of Florida; October 26, Stonybrook School of Medicine; October 27, State University of New York at Buffalo; October 27, University of Missouri—Kansas City; November 1, University of Illinois; November 8, University of Medicine and Dentistry of New Jersey; December 12, Boston University Goldman School of Graduate Dentistry; January 4, University of Mississippi; January 6, University of Minnesota; January 12, University of Texas Dental Branch; January 17, University of Tennessee; January 20, University of Washington; January 22, Medical University of South Carolina; January 27, University of North Carolina; February 3, University of Maryland; February 6, West Virginia University; February 7, Indiana University School of Dentistry; February 8, Oregon Health Sciences University School of Dentistry; February 9, University of Puerto Rico School of Dentistry; February 16, University of Nebraska; and February 19, MeHarry Medical College School of Dentistry.

Seminar Presenters. Instructors were selected by the Council based upon recognized expertise in practice management. In addition, representatives of the respective constituent societies were invited to discuss the important role of organized dentistry. Each seminar included two professionals selected from the Council's list of consultants.

Six new speakers were selected at the May 1996 meeting of the Council after reviewing curricula vitae and videotapes of applicants. These speakers' names will be forwarded to the

ADA Board of Trustees to be considered for appointments as Council consultants. A training session for new speakers is planned for fall 1996 in preparation for the academic year.

SUCCESS 95-96 Program Revisions. Each year the SUCCESS Program is reviewed in light of the changing dental practice environment and student needs. In the March 4, 1996 issue of the *ADA News*, a Request for Proposal (RFP) for SUCCESS speakers appeared. Dentists or practice management consultants interested in becoming presenters were asked to submit their curricula vitae, a history of platform presentations and a three- to five-minute videotape of their presentation styles to CDP by April 3, 1996. The Council reviewed the applications at its May 1996 meeting and selected several new speakers.

A coupon distribution for a free copy of a volume from the Council's SUCCESS Practice Management Series was done this year. This coupon was given to those students in attendance at the conclusion of the Program. In 1994-95, over 692 requests from this coupon were honored. Corporate sponsors were presented with labels and computer disks of all coupon redeemers.

With continued corporate support, this Program will again be offered to dental schools throughout the United States and Puerto Rico and continue to grow in its program offerings. Overall goals remain the same—to make available a quality practice management experience to junior and senior dental students in dental schools who will be entering private practice in the immediate future.

Recommendations for Policy Revisions: The 1995 House of Delegates approved Resolution 15H-1995 (*Trans.*1995:659), which directs that, at least every seven years after adoption, policies should be reviewed for continued appropriateness. The following policies were reviewed in accordance with Resolution 15H-1995.

Use of Dentists-to-Population Ratio. CDP reviewed existing policy on use of dentists-to-population ratios (*Trans.*1984: 538). CDP believed that this policy could be amended by the addition of the word *exclusively* because such ratios might be only one element considered in evaluating dental education or dental care programs. CDP sought joint support for this policy change from the Council on Governmental Affairs and Federal Dental Services (CGAFDS). As a result, CDP and CGAFDS recommend adoption of the following resolution.

16. Resolved, that Resolution 77H-1984 (*Trans.*1984:538), Use of Dentist-to-Population Ratio, be amended by the addition of the word "exclusively" so that the amended policy reads:

> **Resolved,** that the American Dental Association urges all governmental, professional and public agencies and schools of dentistry to refrain from using dentist-to-population ratios exclusively in evaluating or recommending programs for dental education or dental care.

Recognition of Dental Manpower/Dental Demand Imbalance. CDP also reviewed with CGAFDS the policy established by Resolution 105H-1984 (*Trans.*1984:537). It was believed that this policy as currently stated may no longer be accurate, since it requires the Association to recognize that a surplus of dentists exists to meet current demand for dental services. It also states that the Association encourage and assist the constituent dental societies in conducting dental manpower studies, and that the Association encourage and assist constituent dental societies in preparing legislation that may be used to petition state legislatures and governmental bodies with respect to private schools to adjust enrollments in dental schools, if necessary.

The existing policy reads as follows:

> **Resolved,** that public statements made by the American Dental Association be modified to include the recognition that a surplus of dentists does exist to meet the current demand for dental services, and be it further
> **Resolved,** that the ADA encourage and assist constituent dental societies in conducting dental manpower studies to compile data and statistics on the number of dentists and dental graduates needed to serve the demand for care, and be it further
> **Resolved,** that as a result of the foregoing, the ADA encourage and assist constituent societies in preparing legislation that may be used to petition state legislatures and governmental bodies with respect to private schools to adjust enrollment in dental schools.

As a result of their review, the CDP and CGAFDS recommend that the current policy be changed by deleting the first and third resolving clauses and amending the second resolving clause. Therefore, the Councils recommend adoption of the following resolution.

17. Resolved, that Resolution 105H-1984 (*Trans.*1984:537), Recognition of Dental Manpower/Dental Demand Imbalance, be amended by the deletion of the first and third resolving clauses and the amendment of the second resolving clause, so that the amended policy reads as follows:

> **Resolved,** that the ADA continue to conduct dental manpower studies and compile the necessary data and statistics on the number of dentists and dental graduates needed to serve the demand for care and disseminate this information to the appropriate agencies.

Managed Care Market Research: The Council on Dental Practice is conducting comprehensive managed care market research. The components of the managed care market research include a mail survey of 5,000 dentists, a telephone survey of 1,000 consumers, a series of eight consumer focus groups in four cities with high managed care marketplace penetration (Chicago, Boston, San Diego and Minneapolis) and three employer focus groups with large (more than 2,500 employees), medium (200-2,500 employees) and small (fewer than 200 employees) employers. This research will give the Association an extensive array of managed care information from many different perspectives for decision making and new product development. The Council is developing a series of articles to disseminate this information, as well as including it in the managed care seminar and a summary report for general distribution.

Managed Care Products: CDP, with assistance from other Association agencies, has developed managed care products to assist members in understanding managed care and the potential impact it may have on a practice. *A Dentist's Guide*

to Managed Care Marketplace Information helps dentists understand the basic economics of managed care and assess the financial impact on a dental practice. Issues addressed in the *Guide* include the tools of managed care, evaluating managed care programs, antitrust and other legal issues. This publication is available through the Department of Salable Materials for $19.95. Along with the managed care publication, a *Managed Care Resource Packet* is available. The resource packet contains valuable managed care information on a variety of issues including legal issues, contracts, sample speeches, examples of patient letters and managed care terms. The resource packet is free with a purchase of the *Guide* or costs $5.00. A *Financial Impact Analysis of Plan Contracts* is also available through Salable Materials. It is a computer spreadsheet model that estimates the financial effects of various managed care plans, allows dentists to run unlimited "what if" scenarios and determines the range of financial effects a plan may have on a practice. The cost for the computer spreadsheet and accompanying publication is $40.00.

Staff of the Councils on Dental Practice and Dental Benefit Programs published an article in *The Journal of the American Dental Association (JADA)* regarding an analysis of survey data on the premium costs of dental capitated health maintenance organizations. This article looked at the cash streams typically available to practitioners who participate in such plans.

Well-Being Issues: The Council concentrates its well-being activities into three main focus areas: chemical dependency, HIV/AIDS support programs and other general wellness issues. The Council nominated the following members to its Dentist Well-Being Advisory Committee (DWAC) for 1995-96: Dr. Charles Norman, chairman, NC; Dr. Stephen Abel, NY; Gene Abel, M.D., GA; Dr. Thomas Derosier, MA; Dr. Gale Kloeffler, CA; Dr. Andrew Pickens, MT; and Dr. David Webster, KY.

The composition of the Advisory Committee is intended to ensure competent professional input on a broad scope of impairments which affect dentists and their ability to practice.

Chemical Dependency. The Council maintains a significant focus on chemical dependency issues through ongoing communication with well-being chairpersons, yearly revision of the *Well-Being Directory* and assisting in individual requests for consultation and resources. Currently, a new resource manual is being developed to assist volunteers of well-being committees, as well as chairpersons seeking to expand program services.

The Council has been actively participating in the first comprehensive substance abuse study among dentists and dental students through a grant received by the University of Kentucky College of Dentistry, the National Institute for Dental Research and the National Institute on Drug Abuse. The study, initiated in 1994, anticipates completion of data collection by the fall of 1996.

Yearly, the Council sponsors a Well-Being booth at the annual session. The booth highlights several wellness topics and offers a variety of materials on chemical dependency outreach and state contacts for chemical dependency help committees.

In 1993, the Council initiated the inclusion of the four questions known as Cut Down, Annoyed, Guilty, Eye-opener (CAGE) screening for alcohol abuse in the Health Screening Questionnaire during annual session. The CAGE continues to evolve as a dependable assessment tool for primary warning signs of problem drinking.

The manager, Wellness and Assistance Programs, continues to receive calls for assistance from dentists treating patients they suspect are chemically dependent and from dentists seeking help for their own substance abuse. Frequently, calls are also received from families of dentists, requesting help in intervention and referrals.

HIV/AIDS. The Council's Prevention, Education, Ethics, Resources and Support (PEERS) Network for dentists with HIV/AIDS disease continues to grow, now representing more than 60% of states. Two national trainings, sponsored by the Council, have been offered at the Association, the most recent during the Well-Being Conference in July 1995.

The *Resource Manual for Support of Dentists with HBV, HIV, TB and Other Infectious Diseases* was released in the fall of 1995. The manual, a result of Resolution 115H-1993 (*Trans.*1993:696), was mailed to constituent and component societies, well-being chairpersons, PEERS Network volunteers and all U.S. dental schools. The Council has received many positive comments on the usefulness of the information. Several chapters of the manual were also released on the *ADA ONLINE* World Wide Web page in February 1996.

The Council's request for yearly display of the NAMES Project Quilt was accepted by the Council on ADA Sessions and International Programs (CASIP) and the first display debuted in Las Vegas in October 1995. Portions of the Quilt will be displayed each year in a prominent location of the exhibit hall.

Guiding Principles for Dentist Well-Being Programs. The Council reviewed the previous CDP-sponsored resolutions regarding well-being and chemical dependency activities. Several of the resolutions address awareness, education and support, in general. But the Council noted there was a lack of direction regarding the development and scope of services for dentist chemical dependency and well-being committees.

The dentist well-being programs in existence vary widely in organization, services offered and the scope of issues addressed. While some have more sophisticated designs and funding, others vacillate between limited services and no services. To date, there are no established principles for these programs approved by the Association.

The Council met with the American Bar Association Lawyers Assistance Programs and received permission to use their materials as a matrix for organizing a series of guiding principles for dentist assistance programs, based on those for lawyers assistance programs. As a result, the Council recommends adoption of the following resolution.

18. Resolved, that the American Dental Association supports efforts by constituent and component dental societies in the development and maintenance of effective programs to identify and assist those dentists and dental students affected by alcohol or other drug abuse problems, HIV/AIDS, other infectious diseases, or mental or physical conditions which potentially impair their ability to practice dentistry, and be it further

Resolved, that constituent and/or component dental societies be urged to include these guiding principles in establishing or structuring peer assistance programs for dentists:

1. That statewide dentist peer assistance programs be established.
2. That appropriate protection be sought to ensure the confidentiality of those who seek and provide help through authorized programs.
3. That measures be sought to provide those who serve in dentist peer assistance programs immunity from civil liability, except for willful or wanton acts.
4. That strong, but not exclusive, ties with the recovering community be encouraged.
5. That strong working relationships be maintained between state, local and national programs.
6. That dentist peer assistance programs and dental licensure boards be encouraged to establish and maintain a system for referral and monitoring of dentists in need of assistance.
7. That educational activities be developed to inform the public, the judiciary, the dental society, dental students and the dental licensure boards of the assistance that is available.
8. That committee members become familiar with and review the Curriculum Guidelines for Education in Substance Abuse, Alcoholism, and Other Chemical Dependencies (1992) and provide liaison to dental schools to assist in implementation of this curriculum.
9. That continuing education programs on well-being issues be developed and offered to dentists and urge the acceptance of these offerings as a part of Continuing Education requirements, if they exist.
10. That periodic review of the peer assistance programs be conducted.

Other Well-Being Issues. The Council initiated a stress survey in October 1995 during the annual session in Las Vegas. The five-minute inventory, developed by Dr. Gene Abel (DWAC), was offered at the Well-Being Booth and taken by almost 600 dentists. The Council plans to again offer the inventory in 1996 at the annual session in Orlando.

A new marketing brochure for wellness and assistance programs has been developed highlighting several areas of concern for dentists. These brochures will be made available to large conventions, for random mailings and at well-being events.

The Council hosted the 1995 Well-Being Conference, "Of Sound Mind and Body," in July at Association Headquarters. This two-day workshop offered a host of nationally recognized speakers on wellness, chemical dependency, stress/burnout, HIV/AIDS and many other topics. One of the highlights of the conference was a keynote address by Mr. Pat Summerall, sponsored by the Betty Ford Center.

Periodontal Screening and Recording: The Council is involved in the overall implementation of the Periodontal Screening and Recording Program (PSR®). The Association first began this program in late 1990 when seven councils and the Board of Trustees reviewed and approved Association involvement in this project. A work group of Council members, chaired by Dr. George Bletsas, MI, reviewed the scientific basis for the program and recommended that the Association sponsor the program. It is being done in conjunction with the American Academy of Periodontology (AAP) and the Procter & Gamble Company (P&G). The PSR® System is a simple, quick method to provide consistent monitoring and screening for patients' periodontal status.

The program was launched in three phases: Phase I was targeted to the periodontal community; Phase II went to the general dentists at the 1992 ADA annual session; and Phase III is ongoing to the profession and the public in an informational effort about PSR®. A news conference, media speaking tour, video news releases and other promotional materials are part of this endeavor.

Most of the 1995-96 PSR® promotional budget went to direct advertising. PSR® advertisements ran in *JADA* and the *ADA News* as well as several consumer magazines, including *People, Good Housekeeping* and *McCalls*. Paid advertisements in these consumer publications are very expensive and consumed most of the 1995-96 dollars made available by P&G. A 1996-97 promotional plan will be developed after fiscal year end, June 30, 1996, for P&G when its new budget is known.

Dental Economic Advisory Group: The Council works with the Association's Dental Economic Advisory Group (DEAG) to develop projects and resources of an economic nature for members. DEAG was instrumental in assisting with the development of the Council's *Financial Impact Analysis of Plan Contracts* and a *State Reform Cost Estimating Model.* The *Financial Impact Analysis* is currently being made available to dentists through the Department of Salable Materials. The *State Reform Cost Estimating Model* has been made available as a cost projection tool for state dental societies. The *State Reform Cost Estimating Model* has been demonstrated at various Council meetings, at the State Lobbyists' Conference and to representatives at the Health Care Financing Administration.

Child Abuse: In December, the Council completed an extensive revision to its monograph, *The Dentist's Responsibility in Identifying and Reporting Child Abuse and Neglect.* This manuscript contains information about the signs or symptoms of abuse and neglect, the interaction of the dental team and the dentist's role in identifying suspected cases. The publication also shows listings of state reporting agencies and mandated reporters. A general mailing of this publication was done and over 1,500 copies have been distributed to date. It is also listed as a resource to accompany a July 1996 *JADA* article on child abuse.

Forensic Dentistry Issues: The Council, in response to Resolution 98H-1990 (*Trans.*1990:546), Formation of a Dental Emergency Identification Team Clearinghouse, has accumulated information on forensic dental programs in state and local areas and acts as a clearinghouse for this information, distributing it upon request from members. The Council continues to distribute the *Proceedings: First National Conference on Dentistry's Role and Responsibility in Mass Disaster Identification.* The Council will cosponsor the Second National Symposium with the American Board of Forensic Odontology (ABFO), in Chicago, June 28-29, 1996. This meeting is intended to:

- communicate the role of the forensic dentist and others in mass disaster victim identification;
- report on significant cases that used dental clues to establish identity such as in air disasters, serial murders, etc.;
- review the new ABFO Mass Disaster/Body Identification Guidelines;

- describe recent contributions to the science of forensic odontology, such as computer-assisted identification and DNA analysis; and
- learn about the training of disaster teams and the disaster preparedness of air carriers and localities.

Report on Computer Oral Health Record: The Council established a Working Committee on Computer Oral Health Record two years ago with the assignment to assist in the development of an electronic oral health record. The Committee used Association policy stemming from Resolution 18H-1992 (*Trans.*1992:597) as its basis for action. This resolution directed the Association to facilitate the development of electronic dental patient records. The benefits of a computer oral health record include supporting patient care through improved quality, enhancing productivity and enriching research possibilities.

During the course of three meetings of the Working Committee in Chicago, the Committee investigated the basis for developing such a record. Members of the committee heard presentations from leading authorities on the components of the paper record and on the importance of designing a system architecture that is open and that allows for modules to be independently developed, yet which can interface in a seamless fashion. The problem with most so-called computer oral health records that are available from software vendors is that each system is proprietary and usually does not work with other systems. Principally, there are differences in terminology, key relationships in the flow of information, and conflicts in messaging standards (the technical specifications through which components identify themselves and communicate).

The Committee decided that the best approach to starting the project was to embark on a process that would conceptually define the key relationships in a basic way and which might later be freely available to all developers. The construct that frames these relationships is called a "concept model."

An essential distinction of an electronic oral health record is that while the model does not detail the specifics of how patient confidentiality is to be maintained, or how accidental disclosure of patient-identified information is to be prevented, such concepts should functionally be integral to the model. The Committee was concerned with data security and privacy and that the model capture both oral health problems and wellness. In general, the organizational approach of a paper-based oral health record is problem-oriented, yet in modern dentistry the more usual orientation should be toward prevention. Hence, providing for wellness is an important new consideration in designing a concept model for an electronic oral health record.

The Committee isolated the key "entities" that interact before, during and following a patient visit. (An entity is an abstraction of an essential characteristic or component of the model.) Entities may interact, are acted upon and have data that persist. One such entity is the "person" entity—which may be the patient, the dentist or another individual involved in the event. Others entities are "organization," "person role," "patient findings," etc. Each is separated into function views in the model and the complex interrelations are identified.

The Committee was assisted in this highly technical and conceptual analysis by Dr. Mark Diehl, formally of the U.S. Navy, assigned to the Department of Defense (DOD). The DOD has been involved in a similar project developing an oral health record for the Navy's dental facilities across the world. The Committee benefited from that huge research effort which Dr. Diehl coordinated through the DOD.

During its May 1995 meeting, the CDP was able to see the first version of the concept model. Since then, a final "0.9 draft version" was published by the Council with the assistance of the Association's Department of Dental Informatics. This version was shared with the ADA Board of Trustees and sent out for comments to a host of informatics experts around the country during the past summer. With the release of the *Computer-Based Oral Health Record Concept Model*, the working committee was sunsetted.

At the time of the 1995 annual session in Las Vegas, the Council formally shared its model on the national level with all parties interested in further developing this model and adding the technical standards. The reason for presenting the model in an open forum was to enlist common support for a single approach that is exemplified in the CDP concept model. The American National Standards Institute's (ANSI) Accredited Standards Committee (ASC) MD 156, Group 4 is the national body that writes standards of this type for the United States. The fine details now missing from the model will be added by that group and rereleased as a "logical model."

Eventually, when the more detailed logical model is completed by the ASC MD 156, and a standard is accepted, all dental software will then have to meet that standard. This will permit independent developers to produce enhanced software that works on all systems (interconnectivity). A dentist then would no longer be forced to buy all of his or her dental patient software from a single vendor just for the sake of compatibility. Specialty organizations in dentistry will be able to add their domain expertise as compatible modules to the overall computer-based oral health record.

At a later time, the Logical Model coming from ASC MD 156 will be referred back to the Council for review, comments and approval.

The achievement of this Working Committee of CDP is unparalleled in health care informatics and places dentistry ahead of most other health professions that are attempting to develop similar paperless patient care systems and standards. The dental model is designed to work effortlessly with the computer-based medical patient record once it is developed.

Council Publications: The Council has developed a more appropriate title for its practice management library of publications. The new title for the publications is "Practice Management Series." The entire series is being redesigned and retitled to give it a fresh and more marketable look. *Building Successful Associateships* and *Successful Valuation of a Dental Practice* are being revised as part of the Council's ongoing review of the appropriateness of the information in the publications.

The Department of Salable Materials assisted the Council's promotion of its publications and developed a promotional flyer which featured the practice management series books at a special package price for all nine publications. The flyer was targeted to dentists who buy or have had an interest in practice management materials. Other promotion activities include featuring the series in the *ADA Catalog* of materials.

Of the ten revenue-producing materials developed by the Council, *Successful Valuation of a Dental Practice, Building Successful Associateships* and *Successful Office Design* were the most popular.

CDP completed work on the *Employee Office Manual: A Guide to the Dental Practice*. This publication is a team-oriented handbook for both the dentist and team members to utilize, answering hundreds of questions relating to policies in the dental practice. Some of the topic items include the following: methods of finding employees, methods of interviewing and hiring employees, ways to compensate employees, optional benefits for employees, ways to recognize employees, improving communication within the office and termination of employees. Over 2,000 copies of this manual have been sold through the Association's Department of Salable Materials.

At its May 1996 meeting, the Council approved combining two of the financially related publications and withdrew a planned publication on estate and retirement planning. All of the publications are being redone with a more up-to-date cover design, title changes and eye-catching presentation.

Liaison with the Dental Laboratory Industry: The Council continues to maintain formal liaison activities with the dental laboratory industry to allow for discussion of mutual concerns. Three representatives from the National Association of Dental Laboratories (NADL) were in attendance at the Council's November 1995 meeting. At this meeting, NADL representatives presented an updated report of its activities as well as that of the National Board of Certification (NBC) in Dental Laboratory Technology. NADL also expressed its gratitude for the Council's efforts in the passage of Resolution 7H-1995 (*Trans.*1995:623), Amendment of ADA Policy Statement on Prosthetic Care and Dental Laboratories, which amended the shade selection policy.

NADL held its 45th annual session in Washington, D.C. on June 20-25, 1995. The Association President, Council on Dental Practice Chairman and CDP staff attended the meeting. The Association President and CDP Chairman had an opportunity to address the NADL delegates.

The Council continues to annually implement Resolution 28H-1987 (*Trans.*1987:496) regarding recognition for certified dental technicians (CDTs). With assistance from NADL, the Association congratulates each certified dental technician who reaches their 25th anniversary of working in the dental laboratory industry. NADL annually provides the Council with these names. This past year, 125 CDTs were so recognized by a recognition certificate and letter from the Association President. The Council wishes to sincerely thank NADL for its assistance in providing this information to allow greater recognition of the dental laboratory technician as part of the dental team.

Dr. Gerald Carrier, CDP member, has been serving a three-year term on the NBC and attended its biannual meetings. The Council is very supportive of Dr. Carrier's appointment since it allows for expanded communication between NBC and the Council.

Mr. Gary Shapiro, CDT, NADL president, and Mr. Robert Stanley, executive director, were invited guests at the April 1996 meeting of the ADA Board of Trustees. Mr. Shapiro made a presentation about NADL activities and the liaison with CDP.

Denturism Issues: The Council on Dental Practice and the Department of State Government Affairs (DSGA) continue to monitor issues related to denturism and completed a Board directive to develop a denturism resource packet. The packet is available from DSGA and includes information on states with initiative processes, denturism laws, arguments against denturism and strategies to defeat an initiative. CDP has directed that a short survey instrument be developed for use by state societies who wish to conduct research on this subject.

Attendance at the American Dental Hygienists' Association (ADHA) Meeting: Council staff attended the ADHA's 72nd annual session held in Chicago, June 9-12, 1995.

Liaison with the American Dental Assistants Association (ADAA): The Council continues its collaboration with the ADAA by promoting the recognition of dental assistants by annually sponsoring Dental Assistants Recognition Week (DARW). This recognition week occurred in March 1996. The Council worked in cooperation with the Association's Department of Salable Materials to promote DARW recognition pins and hip packs. The Council also distributed institutional advertising "slicks" to over 600 dental editors nationwide through the *Dental Editor's Update* mailing of the Division of Communications. These ads appeared in both *Dental Teamwork* and *ADA News*. ADA staff attended portions of the 71st ADAA annual session during October 4-8, 1995.

Advisory Committee on Dental Team Issues: The Council's Advisory Committee on the Dental Team has provided feedback to the Council on various activities that enhance the relationship among the dental team members. The Committee members are Dr. Stanley Kaczkowski, chairman; Ms. Kim Anderson, RDH, MT; Ms. Bernadette Green, RDH, OH; Ms. Peggy Jabbour, RDH, SC; Ms. Jo Ann Cantrell, RDH, AL; and Ms. Donna Fukuda, RDH, HI. The Committee held its third meeting on April 28, 1995. The Committee developed several ideas for the Council's consideration, including a team building conference, a focus group or survey of team members, various team recognition advertising slick sheets and the promotion of mouth guard awareness. Many of these activities are presently under development, with the most notable activity being a Team Conference in conjunction with the 1996 ADA/FDI World Dental Congress in Orlando. Attendance is expected at 300. Another advisory meeting is planned for later in 1996.

Seminar Programs: Annually, the Council on Dental Practice's Seminar Services cosponsors over 100 practice management and clinical seminars with state, local and national dental organizations. Completing its tenth successful year of operation, the ADA Seminar Series has continued to grow in both popularity and impact. The Seminar Series has been sponsored in 48 states and five countries. The number of dental teams reached by ADA seminar programs has increased from 5,500 participants in 1988 to 16,500 participants in 1995. Program quality remains very high. Seminar attendees continue to rate the overall program and speaker quality a 4.7 on a 5.0 scale of excellence. In 1994 and 1995, 91% of total bookings were CDP-related seminars.

Objective. The Council's primary objective is to offer tripartite organizations nationally known speakers and ADA-developed/ADA-approved continuing education programs as a tangible member benefit at below-market rates to help generate nondues revenue. Programs fees range from $1,500 to $2,700. To date, ADA Seminar Series' speakers have

agreed to present a limited number of programs at a reduced fee. This has served as a valuable membership benefit, especially for those societies with limited resources and access to quality programming.

Program Growth. The Council developed several new programs in 1995. A seminar entitled "The Changing Face of the Marketplace: Is Managed Care Right For You?" was developed in response to Resolution 122H-1994 (*Trans.*1994:648). Presented primarily by staff of the Divisions of Dental Practice and Legal Affairs, the seminar was featured 26 times in 1995 and is scheduled to be presented 16 times in 1996. The Council also approved a seminar on fee-for-service dentistry, developed with the primary objective to teach general practitioners how to have a successful, fee-for-service practice in this changing health care marketplace.

In addition, the Council approved several new programs for inclusion in the 1995-96 ADA Seminar Series and retained 16 programs approved the previous year. Selection includes programs on communication, electronic commerce, TMD, cash flow management and treating patients with special medical concerns. These programs, approved by the Council, were a result of scouting efforts at the 1994 Chicago Midwinter Annual Meeting, the California Dental Association Annual Meeting and the 1994 Thomas P. Hinman Meeting. Program bookings reached a record high of 115 in 1995.

At its May 1996 meeting, the Council reviewed and added several new seminar programs which included infection control and dental unit waterlines, customer service, removable prosthodontics, aesthetics, current technology and office management systems. Negotiations with these seminar speakers are being concluded for inclusion of these programs in the 1996-97 Seminar Series catalog.

Corporate Sponsors. Henry Schein, Inc., and Colwell Systems, Inc., contributed resources in 1995. Henry Schein, Inc., underwrote the ADA Seminar Series and the NEW Seminar for New Dentists. Colwell Systems, Inc., provided funding for three coding seminars.

Seminar Presenters. Program speakers were selected by the Council based upon recognized expertise in the areas of clinical and practice management.

Program Promotion. An annual catalog is produced and mailed to the executive leadership of tripartite organizations and program sponsors. Programs are also promoted via quarterly mailings, through internal and external agency publications (e.g., *Benefit Briefs, ADA News* and various specialty newsletters and journals) and through internal and external agency activities (e.g., President-elect's Conference, Management Conference, ADA's annual session and the Conference on Dental Meetings).

Directory of Dental Practice Appraisers and Valuators: The Council completed work on the second edition of the *Directory of Dental Practice Appraisers and Valuators.* This 73-page publication is a listing of individuals and companies involved in practice valuation. The *Directory* is organized by state and alphabetically by name. It provides essential background information of use to dentists wishing to choose a professional dental practice valuator. Data contained in the publication is supplied by each listed company in order to characterize the manner or method(s) of their operation and to identify the principals. Nonaffiliated valuators, in the same fashion, also provide detailed information about their education and training, relevant licensing, number of valuations to date, fee and expense requirement, valuation method(s) used, etc. A form requesting characterization information was sent from the Council and completed by the company or individual valuator interested in appearing in the publication. The returned form was reproduced wholly in the publication without endorsement.

Since 1994 a modest fee has been charged valuators for listing in the *Directory.* This fee helps defray expenses connected with printing and distributing the publication free to members. Over 1,000 requests for the *Directory* are fulfilled yearly.

Marketing Assistance: Annually, approximately 500 members call the Dental Practice Marketing Department to receive individual marketing consultations or request information in addition to other marketing resource materials. The Department gathers data from multiple sources on professional services marketing, dental industry trends and consumer attitudes. The Department maintains files on a variety of marketing topics and sends information upon request. The Department also has developed a new marketing resource called *Marketing Tactics to Help Build Your Practice.* Marketing tactics are listed by topics including: creating an identity, connecting with your community and building patient relationships. Three hundred and thirty-five copies have been sent to members free of charge. Additional brochures have been made available at various dental meetings.

Marketing Publications: Three new marketing handbooks will be available this year for purchase through the Department of Salable Materials. *How to Develop a Practice Newsletter* explains how newsletters can be used as an educational tool for patients and referral sources as a promotional technique to build the practice. The second handbook is on maximizing referrals. It will focus on utilizing referrals as a key component in building a practice and attracting new patients. The third handbook is a companion to *How to Develop a Practice Newsletter.* It will contain sample newsletter articles that can be included in any newsletter.

CDP is also working with CAPIR on a publication to address nontraditional practice settings. This publication will highlight several different types of practices in nontraditional settings and encourage dentists to develop such a practice.

Patient Satisfaction Survey Service: CDP launched a patient satisfaction survey service, ADA-CheckUp, for dentists to determine their patients' level of satisfaction with many aspects of the staff and practice. This service is done in conjunction with an external vendor, CheckUp. The overall response has been very positive. Since the service launch, 1,247 brochures have been sent, 18 jobs have been started and five have been completed.

Cost to members is about $1.00 per survey. The total estimated cost to conduct the patient satisfaction survey in a dental practice averages about $250-$1,000, depending on the number of surveys conducted.

Practice Listing Services: The Council routinely receives telephone inquiries regarding the placement of associates in dental offices. The *Directory of Dental Placement Services in the United States* continues to be available upon member request. This resource, updated in January 1996, lists the various placement services that are operating throughout the nation. It includes services that list dentists as well as office personnel. The Council annually receives approximately 750-1,000 requests for this *Directory*.

As a companion document to the *Directory*, the Council published *Guidelines for Establishing a Dental Placement Service*. These *Guidelines* are designed to serve as a step-by-step aid to those organizations operating a placement service.

Practice Management Articles/Topics: The Council is actively involved in identifying and developing articles and topics relevant to current needs on practice management. Several practice management-related articles appeared in the *ADA News* and *JADA*. This year these articles covered, among other topics, computers, well-being issues, HIV/AIDS issues, tax law amendments affecting practice sales and the Periodontal Screening and Recording Program.

General Information Resource: The Council receives approximately 350 telephone inquiries and written requests each month for general practice management, marketing, well-being and seminar information.

Summary of Resolutions

16. Resolved, that Resolution 77H-1984 (*Trans.*1984:538), Use of Dentist-to-Population Ratio, be amended by the addition of the word "exclusively" so that the amended policy reads:

> **Resolved,** that the American Dental Association urges all governmental, professional and public agencies and schools of dentistry to refrain from using dentist-to-population ratios exclusively in evaluating or recommending programs for dental education or dental care.

17. Resolved, that Resolution 105H-1984 (*Trans.*1984:537), Recognition of Dental Manpower/Dental Demand Imbalance, be amended by the deletion of the first and third resolving clauses and the amendment of the second resolving clause, so that the amended policy reads as follows:

> **Resolved,** that the ADA continue to conduct dental manpower studies and compile the necessary data and statistics on the number of dentists and dental graduates needed to serve the demand for care and disseminate this information to the appropriate agencies.

18. Resolved, that the American Dental Association supports efforts by constituent and component dental societies in the development and maintenance of effective programs to identify and assist those dentists and dental students affected by alcohol or other drug abuse problems, HIV/AIDS, other infectious diseases, or mental or physical conditions which potentially impair their ability to practice dentistry, and be it further

Resolved, that constituent and/or component dental societies be urged to include these guiding principles in establishing or structuring peer assistance programs for dentists:

1. That statewide dentist peer assistance programs be established.
2. That appropriate protection be sought to ensure the confidentiality of those who seek and provide help through authorized programs.
3. That measures be sought to provide those who serve in dentist peer assistance programs immunity from civil liability, except for willful or wanton acts.
4. That strong, but not exclusive, ties with the recovering community be encouraged.
5. That strong working relationships be maintained between state, local and national programs.
6. That dentist peer assistance programs and dental licensure boards be encouraged to establish and maintain a system for referral and monitoring of dentists in need of assistance.
7. That educational activities be developed to inform the public, the judiciary, the dental society, dental students and the dental licensure boards of the assistance that is available.
8. That committee members become familiar with and review the Curriculum Guidelines for Education in Substance Abuse, Alcoholism, and Other Chemical Dependencies (1992) and provide liaison to dental schools to assist in implementation of this curriculum.
9. That continuing education programs on well-being issues be developed and offered to dentists and urge the acceptance of these offerings as a part of Continuing Education requirements, if they exist.
10. That periodic review of the peer assistance programs be conducted.

Commission on Relief Fund Activities

Patenaude, Raymond J., Maine, 1996, chairman
Cascio, Samuel J., Illinois, 1996, vice chairman
Ferris, Geraldine M., Florida, 1999
Hazel, Michael C., Oregon, 1997
Schoenfeld, Franziska I., Michigan, 1997
Sprowl, Harvey D., New York, 1998
Thomas, Joe C., Arkansas, 1999
Wessinger, N. Carl, South Carolina, 1998
Bramson, James B., director
Mountz, Marsha L., manager

Meetings: The Commission met in the Headquarters Building on August 25, 1995 and March 14-15, 1996. Dr. Robert L. Bartheld, second vice president and Board of Trustees liaison to the Commission, attended the March meeting. A meeting of the Commission is scheduled for August 16, 1996.

Election of Chairman and Vice Chairman: The 1989 House of Delegates adopted Resolution 44H-1989 (*Trans.*1989:557), which amended the *Bylaws* to allow the Commission on Relief Fund Activities to elect its chairman. Dr. Raymond J. Patenaude was elected chairman and Dr. Samuel J. Cascio was elected vice chairman at the August 25, 1995 meeting.

The Strategic Plan of the American Dental Association: The Commission's program relates to the Association's overall mission statement regarding assistance to the profession and the public at large. Grant assistance is given to those eligible dentists and their families to ensure that they maintain an acceptable standard of living while facing adversity. The Relief Fund activities promote the profession of dentistry by enhancing the integrity and ethics of the profession and its members. The Commission's program supports Objectives 2, 3 and 6 of the Association's Strategic Plan.

Objective 2: Association Program and Financial Plan. The Commission's charitable work contributes to the overall program activity and positively promotes the Association's visibility. Through the Commission's Relief Fund Campaign, monies are raised for disbursement to state society relief funds.

Objective 3: Membership Recruitment and Retention. Charitable activity through the Relief Fund is seen as a professional, altruistic method to assist colleagues. This affects the Association's ability to be positively viewed by the dentist. In addition, the Relief Fund works in a cooperative manner with constituent and component society relief funds to identify, evaluate and help needy individuals.

Objective 6: Professional Image. The commendable purpose of the Relief Fund enhances the image of dentists and the profession as a whole. Few other health care professional groups have established charitable entities for assisting needy colleagues as the Association has done through the Relief Fund.

Amendments to the ADA Relief Fund *Rules*: In July 1995, the Commission was asked by the Kansas Dental Association to review the Relief Fund *Rules* regarding the criteria for submission of audit reports by constituent society relief funds. At that time, the *Rules* stated that any constituent society relief fund that consistently has a balance below $20,000 is permitted to submit a substitute statement for the required five-year audit, if signed and certified by two officials of the state relief fund. This policy was implemented to protect those relief funds with small balances from paying audit fees which could be viewed as excessive compared with the funds' balances.

The Commission reviewed the balances of constituent society relief funds and was sensitive to those with small balances that pay audit fees ranging from $3,000—$5,000. In some instances, the audit fee would diminish a society's level of grant participation. Therefore, the Commission proposed an amendment to its *Rules* to allow relief funds with balances under $50,000 to file the substitute statement. The Board of Trustees adopted Resolution B-165-1995 (*Trans.*1995:581) to amend the Relief Fund *Rules* at its December 1995 meeting.

Program Activity: The ADA Relief Fund, in concert with constituent and component dental society relief funds, provides financial assistance to dentists and their families when illness, accidental injury or advanced age prevents them from employment and results in their inability to be self-sustaining. Grants are awarded to meet daily living expenses.

As of June 30, 1995, the total number of persons receiving grants was 94, of which 11 were initial grants, four were emergency grants and the balance were renewals. In addition, the combined grant amount from the ADA Relief Fund and constituent society relief funds awarded to needy recipients was $653,775 as of June 30, 1995. The average monthly grant awarded in 1995 was $840, compared with $806 in 1994; the largest monthly grant awarded was $2,500, compared with $2,000 in 1994; and the amount of the largest emergency grant given in 1995 was $20,000, compared with $10,000 in 1994. Over the last two years, the average dollar amount of the grant requests has increased.

Financial Operations: As of June 30, 1995, the ADA Relief Fund contributions generated by the 1994-95 annual fund-raising campaign amounted to $355,161, of which $293,755 was rebated to constituent society relief funds. The Commission established a base of $250,000 to determine each state's campaign quota.

From the ADA Relief Fund, $325,198 was disbursed in the form of grants as of year-end 1995. Other expenses included: general and administrative, $213,175; investment and bank fees, $58,786; professional audit and accounting fees,

$23,200; consulting fees, $7,715; solicitation campaign expenses, $68,683; and credit card charges, $480. As of December 31, 1995, the Relief Fund had an unaudited balance of $5,224,055 to support its charitable program activity.

Investment Activities: The Relief Fund's portfolio is currently managed by Westfield Capital Management, Inc., and Becker Capital Management, Inc., equity investment managers; Cutler & Company, Inc., fixed income manager; and LaSalle National Trust, custodian.

The Commission employs a portfolio monitoring service, Performance Analytics, Inc. (PAI), which evaluates the performance of the Relief Fund's investment advisers; compares the portfolio performance of the Fund's managers with that of 3,000 money managers who have accounts similar in nature to the Relief Fund; and reports to the Commission on a quarterly basis. In addition, PAI conducts manager and custodial searches and provides the Commission with investment trends, which allows it to execute its fiduciary responsibilities.

In November 1994, the Commission hired a value equity manager, Becker Capital Management, Inc., to complement the investment style of the growth equity manager at the time, George D. Bjurman & Associates. After reviewing the performance of Bjurman for 1994 and the first quarter of 1995, the Commission directed PAI, its portfolio monitoring service, to conduct a search for a growth manager. After interviewing several candidates in May 1995, the Commission chose Westfield Capital Management, Inc., as the growth manager of the Fund's equity segment.

The fixed income manager invests the Fund's holdings in government and nongovernment securities. At both its March and August 1995 meetings, the Commission studied the performance record of its fixed income manager, First Chicago, for year-end 1994 and the first two quarters of 1995. After its review, the Commission directed PAI to obtain investment data and performance results from other fixed income managers for comparison. Due to the management style and investment philosophy of the staff at Cutler & Company, Inc., the Commission in November selected Cutler to manage the fixed income portion of the Relief Fund.

In August 1995, the Commission reviewed the custodial arrangement that it had with First Chicago and asked PAI to obtain management reports and fee schedules from other custodians with accounts similar in composite to the Relief Fund. After comparing investment results coupled with fees charged for services, the Commission chose LaSalle National Trust as its custodian in December 1995.

The investment managers invest the portfolio's holdings in accordance with the Master Statement of Investment Guidelines adopted by the Commission. In addition, as a matter of policy, the investment managers are prohibited from purchasing securities in any corporation that manufactures, fabricates, processes, sells or furnishes dental supplies, machinery, equipment and materials; dentifrices or other agents related to oral hygiene; or tobacco products.

In 1995, the asset distribution of the entire Relief Fund comprised 70% high grade stocks, 28% government bonds and 2% cash. In the fixed income segment managed by First Chicago, the return for 1995 was 11.3% compared with the Merrill Lynch Government/Corporate Master Index return of 19.1%. The Fund's equity segment had a return of 15.3% for year-end 1995 compared with the S&P 500 composite return of 37.6%. The reason for the performance difference between the Fund and the S&P 500 was twofold. First, the portfolio was in a transition phase with two newly hired equity managers who were changing the profile of the portfolio to accommodate their investment philosophy, resulting in less than fully invested positions in equities for part of 1995 (cash holdings underperformed the market significantly in 1995). Second, the previous equity manager continued to underperform the market in early 1995 due to the type of portfolio holdings while the Commission was completing its search. It was this performance and a desire by the Commission to seek both a value and a growth manager that solidified Commission decisions to restructure its portfolio management. Total equity assets were distributed over 22 major industries with health care and technology services comprising 24% of the asset allocation.

1995-96 Relief Fund Campaign: The Commission conducts an annual campaign to solicit charitable contributions on behalf of the Relief Fund. The fund-raising campaign consists of three mailings, the first of which was sent November 10, 1995 and the second on February 15, 1996; the third is planned for mid-May. Total contributions through April 1, 1996 amounted to $298,947.33. Acknowledgment letters are sent after each mailing to those dentists who contribute $5 or more.

The Commission appreciates the continued support of those members of the dental community who, through their contributions, have helped those less fortunate dentists and their families improve their quality of life.

Resolutions: This report is informational in nature and no resolutions are presented.

Division of Education

Council on Dental Education
and Commission on Dental
Accreditation

Joint Commission on National
Dental Examinations

Notes

Council on Dental Education and Commission on Dental Accreditation

* **Wilson, Richard D.**, Virginia, 1996, chairman, American Dental Association
* **Brotman, Don-N.**, Maryland, 1996, vice chairman, American Association of Dental Examiners
Babcock, Christopher C., Kentucky, 1997, student member
Beemsterboer, Phyllis L., California, 1999, American Dental Hygienists' Association
* **Brandstetter, Dennis J.**, Minnesota, 1997, American Dental Association
* **Broussard, Jack S., Jr.**, California, 1998, American Dental Association
* **DePaola, Dominick P.**, Texas, 1996, American Association of Dental Schools
* **Ferrillo, Patrick J., Jr.**, Illinois, 1997, American Association of Dental Schools
Goodboe, George E., Florida, 1997, National Association of Dental Laboratories
* **Hutchinson, Rowland A.**, Kentucky, 1999, American Association of Dental Schools
Matheson, Madonna Cord, California, 1996, public member
Monehen, Rosemary, Florida, 1996, American Dental Assistants Association
* **Myers, David R.**, Georgia, 1998, American Association of Dental Schools
* **Peterson, Ronald J.**, Arizona, 1997, American Association of Dental Examiners
* **Rossa, Joseph W.**, Illinois, 1999, American Association of Dental Examiners
Rozier, R. Gary, North Carolina, 1997, American Association of Public Health Dentistry
* **Smiley, Colette R.**, Michigan, 1999, American Dental Association
*† **Sweet, Timothy**, New York, 1996, *ex officio*
Van Hassel, Henry J., Oregon, 1996, American Association of Endodontists
* **Watkins, James D.**, Virginia, 1998, American Association of Dental Examiners
Williamson, James A., Maryland, 1998, public member
Hart, Karen M., interim director, Commission on Dental Accreditation
Nix, Judith A., director, Council on Dental Education
Schuhrke, Lois L., director, Center for Educational Development and Research

Meetings: The Council met in the Headquarters Building, Chicago, on July 27-28, 1995; October 27-28, 1995; and April 19-20, 1996. The Commission conducted its meetings on July 27, 1995 and January 24, 1996. Standing and review committees, which provide comments and recommendations on policy and accreditation matters, met immediately prior to the July 1995 and January 1996 meetings of the Council and Commission.

The Council and Commission liaisons from the Board of Trustees, Dr. H. Raymond Klein, trustee, Fifth District, and Dr. Kay F. Thompson, trustee, Third District, attended the July Council and Commission meetings. The Council and Commission liaison from the Board of Trustees, Dr. S. Timothy Rose, trustee, Ninth District, attended the Council's October and April meetings and the Commission's January meeting.

Personnel: The Council and Commission acknowledged with appreciation the many significant contributions made by Dr. Don-N Brotman, Dr. Dominick DePaola and Dr. Richard Wilson upon completion of their terms as Council and Commission members. Commendations and appreciation were also extended to Mrs. Madonna Cord Matheson, Ms. Rosemary Monehen and Dr. Henry Van Hassel, who served as Commission members.

* Council on Dental Education Member
† Standing Committee on the New Dentist member without the power to vote.

Commission on Dental Accreditation

The Strategic Plan of the American Dental Association: The Commission supports the Strategic Plan of the Association in its activities directed toward improving the quality of dental education through the accreditation process. The accreditation process itself is continually reviewed in order to make it more effective and more efficient, both for the Commission and for the institutions and programs that are accredited. The Commission recognizes the need to adapt to changing environmental factors, develop long-range goals and focus Commission activities over the next few years.

Summary of Accreditation Actions: The Commission's accreditation actions from July 1995 through January 1996 are summarized in Table 1 (page 68). At the July 1995 and January 1996 meetings, 347 accreditation actions were taken. These actions were based on site visit reports; progress reports submitted by educational institutions detailing the degree to which specific recommendations included in previous evaluation reports had been implemented; and applications for initial evaluation of education programs. As indicated in Table 2 (page 68), the total number of educational programs currently accredited is 1,295, representing a decrease of one program from the previous reporting period. The Commission *Rules* stipulate that when the Commission anticipates denial or withdrawal of accreditation, it must inform the institution of its right to appeal the proposed action prior to final action being taken. There were no such appeals during the reporting period. Because accreditation is voluntary, accreditation may also be

discontinued at any time during the process upon written request of the sponsoring institution.

Enrollment: Enrollment in accredited dental and dental-related educational programs during the 1995-96 academic year and the number of 1995 graduates are reported in Table 3 (page 69). In 1995, a total of 4,153 first-year students entered dental schools, representing a 3.4% increase from the 4,017 new students in 1994. When students who are repeating their first-year studies are added, the 4,237 students enrolled in the first year of dental school in 1995 constitutes a 2.8% increase over the 4,121 first-year students enrolled in dental school in 1994. This increase represents the fifth increase reported in predoctoral first-year students in the past 14 academic years. The number of 1995 dental school graduates increased by 0.9% from 3,875 to 3,908 during the previous year. The first-year enrollments for dental assisting and dental hygiene programs increased 3.9% and 1.8%, respectively. The first-year enrollment for dental laboratory technology programs decreased by 9.3%. There was a 0.7% increase in advanced specialty first-year enrollments and a 2.2% decrease in first-year enrollment in advanced general dentistry programs. The total number of students enrolled in advanced education programs increased by 61 students (1.3%). Currently, 40,617 students are enrolled in accredited dental and dental-related education programs in the United States. This represents an increase of 1.9% from the previous academic year.

Table 1: Accreditation Actions: July 1995—January 1996

	Dental	Advanced Education Specialty/General		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible					6		6
Preliminary Provisional Approval		2	10	4			16
Approval	8	76	43	35	47	4	213
Conditional Approval		15	15	27	9	2	68
Provisional Approval		3	4	2	7		16
Accreditation Denied				6	2		8
Discontinued Programs		3	7	5	2	2	19
Accreditation Withdrawn		1					1
Number of Accreditation Actions	8	100	79	79	73	8	347

Source: Commission on Dental Accreditation

Table 2: Number of Accredited Programs: January 1996

	Dental	Advanced Education Specialty/General		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
Accreditation Eligible		8			7		15
Preliminary Provisional Approval		13	24	6			43
Approval	54	398	299	209	205	33	1,198
Conditional Approval		5	6	16	3	1	31
Provisional Approval		1	3	2	2		8
Number of Programs	54	425	332	233	217	34	1,295

Source: Commission on Dental Accreditation

Table 3: Enrollment and Graduate Summary: January 1996

	Dental	Advanced Education Specialty/General		Dental Assisting	Dental Hygiene	Dental Laboratory Technology	Total
First Year Enrollment	4,237	1,211	1,230	6,889	5,669	798	20,034
Percent Change	2.8	0.7	-2.2	3.9	1.8	-9.3	1.9
Total Enrollment	16,552	3,218	1,425	7,210	10,882	1,330	40,617
Percent Change	1.2	2.1	-0.3	4.2	2.6	-5.3	1.9
Number of Graduates	3,908	1,135	1,273	4,679	4,668	510	16,173
Percent Change	0.9	-1.3	0.6	4.2	2.5	-16.1	1.4

Source: ADA Survey Center

Revision of Accreditation Standards: The Commission has *Bylaws* authority for the development and revision of educational standards for all programs falling within its accreditation purview. Accreditation standards are revised when there is a specific demonstrated need for a revision. Because of the significant impact of new standards on the resources of postsecondary institutions, the Commission considers the revisions with care and does not initiate the process unless the need for revision has been adequately documented. Currently, a number of activities related to standards revision are being conducted by the Commission. The progress of several of these activities was reported to the 1995 House of Delegates (*Reports* 1995:69).

Revision of Accreditation Standards for Dental Education Programs. At its July 1995 meeting, the Commission reviewed a proposed revision to the predoctoral accreditation standards, as reported to the 1995 House of Delegates (*Reports* 1995:69; *Supplement* 1995:286). The proposed revised standards were circulated to the communities of interest for comments, including open hearings at the Association's 1995 annual session and the 1996 annual session of the American Association of Dental Schools (AADS). In May 1996, the Standards Revision Subcommittee reviewed all written and oral comments; a further-revised document and an implementation date will be considered by the Commission at its July 1996 meeting.

Revision of Accreditation Standards for Advanced Education Programs in General Practice Residency and General Dentistry. The Commission has reviewed progress reports detailing suggested timetables for development of revised standards for Advanced Education Programs in General Practice Residency (GPR) and General Dentistry (AEGD). The Commission expects to review the proposed revised AEGD Standards and GPR Standards at its January 1997 meeting. An implementation date of July 1998 has been proposed.

Revision of Accreditation Standards for Advanced Education in Pediatric Dentistry. At its January 1996 meeting, the Commission reviewed proposed revisions of the Accreditation Standards for Advanced Specialty Education Programs in Pediatric Dentistry. The Standards were approved as amended for circulation to the communities of interest for review and comment and presented at an open hearing during the 1996 annual session of the AADS. The comments from the communities of interest will be reviewed at the Commission's July 1996 meeting. A proposed implementation date of July 1997 was established.

Revision of Accreditation Standards for Advanced Education Programs in Endodontics. At its January 1996 meeting, the Commission reviewed proposed revisions of the Accreditation Standards for Advanced Specialty Education Programs in Endodontics. The Standards were approved as amended for circulation to the communities of interest for review and comment and presented at an open hearing during the 1996 annual session of the AADS. The comments from the communities of interest will be reviewed at the Commission's July 1996 meeting. A proposed implementation date of July 1997 was established.

Revision of Accreditation Standard for Outcomes Assessment. The Commission adopted a revised outcomes assessment standard for all 14 accredited disciplines and established an implementation date of July 1, 1996 (*Reports* 1995:69). The standard requires that the assessment of outcomes by accredited programs include, as appropriate, the evaluation of the results of course completion, state licensing examination results and job placement rates. Subsequent to the adoption of the standard, the Commission adopted an additional revision of the oral and maxillofacial surgery and dental assisting standards to require evaluation of certification examination data as part of their outcomes assessment for these programs. The implementation date remains July 1, 1996.

Revision of Policies and Procedures Related to the Accreditation Process: The Commission is responsible for developing and publishing policies and procedures in order to conduct the accreditation process.

Revision of Commission Policies Related to the Classifications of Accreditation and the Accreditation Cycle. In July 1995, the Commission considered a proposal to revise its accreditation status definitions and its accreditation cycle in response to changes in the requirements of the United States Department of Education (USDOE). The proposal included using only the accreditation status of "approval" but for varying time periods. The accreditation cycle would remain at seven years, but, for programs with significant deficiencies, a special site visit would be conducted within one or two years of the regular site visit to ensure that corrective measures have been instituted. By USDOE requirement, any program not correcting its deficiencies at that time would have its accreditation withdrawn. The Commission believed these changes are of such importance that it circulated the proposed changes to the communities of interest for comment. In addition, an open hearing was held during the 1996 annual session of the AADS. The Commission will consider the received comments on the proposed changes in accreditation definitions and cycle at its July 1996 meeting.

Revised Policy on Nondiscrimination. The Commission has revised its 1984 policy on nondiscrimination as follows: *"The Commission on Dental Accreditation does not discriminate against any person in the conduct of its activities because of race, color, religion, gender, age, disability or national origin."*

Policy on Principles of Integrity. Concerned with how best to ensure that programs and institutions provide accurate information, the Commission has adopted a policy on Principles of Integrity. The policy describes what actions are available to the Commission when deliberate falsification of information occurs, including supporting the costs of any investigations related to breaches. Evidence of violations may affect the program's accreditation status.

Policy on Obtaining Third-Party Comments in the Accreditation Review Process. The Commission has adopted a policy statement to address obtaining third-party comments relative to programs being reviewed as required in the USDOE's *Procedures and Criteria for Recognition of Accrediting Agencies.* Any individual wishing to provide information about an accredited program to the Commission for review during a site visit is invited to do so. Since its adoption of the policy, the Commission has received third-party comments related to approximately six programs scheduled for site visits in 1995 and 1996.

Procedures Related to Reporting Major Changes. The Commission has recognized that programs have not consistently reported major changes to the Commission, as required. Because the USDOE expects its recognized accrediting agencies to place greater emphasis on monitoring programs throughout the accreditation period, the Commission has added questions to its annual surveys of programs that ask if major changes have been implemented and not previously reported. If so, the program must provide a description of the change(s). Based on this information, the Commission can take further action if necessary.

Accreditation Review Process for Dental Programs Specifically Designed for Foreign Graduates: At its July 1995 meeting the Commission reviewed information related to the admission of graduates of foreign dental schools into U.S. dental schools and the accreditation of the educational programs. The Commission noted that three schools admitted graduates of foreign dental schools into special programs designed specifically for these graduates with separate faculty, separate courses and separate clinical arrangements. The Commission believed it needed a more defined accreditation process to ensure careful evaluation of these separate programs. The Commission directed that, for dental schools that offer separate and distinct dental educational programs for graduates of foreign dental schools, these programs complete a separate accreditation self-study report; be site-visited by the core visiting committee, including an additional consultant, if necessary; have a separate site visit report written; and be accredited separately from the core dental education program.

Approval of Oral and Maxillofacial Surgery Fellowship Programs: The Commission has endorsed a proposal to initiate a process to approve oral and maxillofacial surgery fellowship training programs. In July 1996, the Commission anticipates reviewing further plans, including fellowship training standards and self-studies, as well as consultant training activities.

Pilot Study on the Use of Scoring Grids: The Commission has endorsed a two-year pilot study calling for the use of a scoring grid in the evaluation of accredited oral and maxillofacial surgery programs. The Commission believes that such a system might afford a more objective determination of a program's accreditation status and a greater level of calibration and consistency among consultants. Results of the study will be reported to the House of Delegates.

Commission's Re-recognition Reviews by USDOE and CORPA: The Commission is recognized by the Secretary of the U.S. Department of Education (USDOE) and by the nongovernmental Commission on Recognition of Postsecondary Accreditation (CORPA) as the only recognized accrediting agency for dentistry (*Reports* 1995:71). During the latter part of 1995, the Commission prepared its own self-studies for the purpose of obtaining re-recognition from the USDOE and CORPA. In a letter dated February 1, 1996, the Secretary of the USDOE informed the Commission that its recognition has been renewed for a period of five years, the maximum recognition period. The Secretary has requested that the Commission submit an interim report by November 1, 1996 demonstrating strengthened compliance with several of the USDOE *Criteria for Recognition.* In a letter dated March 8, 1996, the Commission was informed that CORPA granted continued recognition for a period of five years. Staff were commended for their efforts in preparing and documenting the Commission's petitions for re-recognition.

Report to the Institute of Medicine Committee: The Commission has also studied the recommendations of the Institute of Medicine's (IOM) report and discussed which of those recommendations would be helpful in improving the quality of dental education through the accreditation process. Many of the recommendations are being addressed by the Predoctoral Standards Revision Committee in the revised Accreditation Standards for Dental Education Programs. The Commission forwarded a report on its IOM activities to the Board of Trustees' Special Board Committee to Study the IOM Report.

Meeting with the Dental Specialty Group: During 1995, representatives of the Commission continued dialogue on matters of mutual interest with members of the Dental Specialty Group (DSG). The DSG comprises the officers, executive directors and representatives of the eight recognized dental specialty parent organizations. In a special appearance before the Commission in July 1995, the DSG requested that six additional members be added to the Commission to provide for a permanent appointee for each dental specialty organization. The Commission has considered the issue of its structure many times since it was created and assumed its accrediting responsibilities in 1975. The Commission postponed definitely the request from the DSG, pending the outcome of the Association's special committee studying the structure and function of councils and commissions. The Commission also directed that representatives of the Commission continue to meet with the DSG to provide the opportunity for continued dialogue.

Council on Dental Education

Council on Dental Education Strategic Planning: During its October 1995 meeting, the Council discussed its strategic planning priorities for 1996 in conjunction with the Association's Strategic Plan. The Council noted that many of its priorities for 1996 focused on activities in progress (i.e., competency issues, licensure issues, continuing education activities and specialty recognition). Additionally, the Council had preliminary discussion of directives from the 1995 House of Delegates. The Council also agreed that study of the recommendations contained in the 1995 Institute of Medicine (IOM) Report should continue.

Issues related to the relationships between the practitioner and the dental educational community were a significant part of the Council's strategic planning discussion. The Council agreed that this issue should continue to be addressed during the coming year. The Council's priorities for the coming year included discussion of these issues with the American Association of Dental Schools (AADS).

Other activities related to the Council's 1996 strategic planning priorities are described throughout this report. Some activities are in the initial stage of development, and progress on their implementation will be reported as they develop. The Council views its strategic planning activities as a high priority and devotes time during its October meeting to identify its strategic plans for the coming year in conjunction with review of the Association's Strategic Plan and assignments from the House of Delegates.

Dental Education

Competency Assessment in Predoctoral Programs: In October 1995, the Council considered an informational report on competency assessment and definition. The Council supported the efforts of the AADS to identify and define the competencies that must be demonstrated by predoctoral students for graduation, as a basis for development of a competency-based curriculum. At the Council's suggestion, in August 1995 the ADA Board of Trustees approved $15,000 in partial funding for an AADS Predoctoral Competencies Development Workshop and appointed an ADA representative to the October 18-21, 1995 workshop.

Council on Dental Education Response to the Institute of Medicine Report: As indicated in its 1995 annual report (*Reports* 1995:71), since April 1995, the Council has devoted significant time to review and discussion of the recommendations contained in this report. Council members developed written reports discussing individual IOM recommendations. This information was subsequently collated, summarized and provided to the Special Board Committee to Study the IOM Report. Additionally, the Council reviewed Resolutions 91H, 99H and 104H (*Trans.*1995:644, 641, 642) related to the IOM Report, which were adopted by the 1995 House, as well as Resolution 105 (*Trans.*1995:643), which was referred by the House to the Council for study.

During the past year the Council directed its attention to IOM Report recommendation 6, which addresses development of a clinical model for patient care in dental schools, and recommendation 22, which addresses issues associated with recruitment and advancement of minority students, faculty and staff. Recognizing that these issues are of common concern to the dental educational community, the Council has also begun discussions with the AADS concerning each issue and will continue to address these concerns in close collaboration with the dental educational community.

The Council will continue to utilize the IOM report as a reference as it works to implement activities in conjunction with its strategic planning initiatives.

Specialty Recognition

The American Academy of Oral and Maxillofacial Radiology's Request for Recognition of Oral and Maxillofacial Radiology as a Dental Specialty: On January 1, 1996, the American Academy of Oral and Maxillofacial Radiology (AAOMR) submitted an application for recognition of oral and maxillofacial radiology as a dental specialty. The application included information and documentation relating to the sponsoring organization and to the six requirements for dental specialty recognition specified in the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*.

In accordance with Council policy, notification of receipt of the application was transmitted to ADA constituent and component societies, recognized specialty organizations and certifying boards, the American Association of Dental Examiners and the American Association of Dental Schools through a letter from the Council Director dated January 10,

1996. A notice to the profession regarding receipt of the application was published in the January 22, 1996 issue of the *ADA News*. Comments on the application from interested individuals and organizations were invited.

The Committee on Dental Specialty Recognition (Committee G) reviewed the application during a meeting held at the ADA Headquarters Building on February 28, 1996. The Council reviewed the application during its meeting on April 20, 1996. All submitted information was evaluated in light of the established requirements for the sponsoring organization and for specialty recognition to determine the extent to which compliance with each requirement had been demonstrated. It should be noted that the Committee's task was to review the application submitted by the AAOMR, not the field of oral and maxillofacial radiology in a broader sense beyond the application. The burden of proof regarding compliance with the requirements rests with the sponsoring organization and was assessed on the basis of the specific information submitted in the application and comments on the application.

In considering the information provided in the application, Committee G also considered supplemental information provided by the AAOMR in correspondence dated February 7, 1996.

Assessment of Compliance With Each Requirement.

> **Requirement 1:** In order for an area to be recognized as a specialty, it must be represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.

Based on the information provided in the application, the Council believed that the AAOMR's membership is reflective of the special area of practice. The application presents evidence that the AAOMR is recognized throughout the world as the organization representing oral and maxillofacial radiology in the United States. Further, the Council noted that in 1979 the AAOMR established a certifying board. Completion of an oral and maxillofacial radiology program of at least two years in length is required to qualify for the examination.

The application notes that the AAOMR is in the early stages of developing parameters of care. The Council urges the AAOMR to continue efforts to establish parameters of care.

After review of all information contained in this section of the application, the Council believed that the AAOMR demonstrated that its organization is reflective of the special area of practice and has demonstrated the ability to establish a certifying board. Its membership is actively involved in promoting training for dentists in oral and maxillofacial radiology at the predoctoral, advanced and continuing education levels. For these reasons, the Council believed that the AAOMR demonstrated compliance with this requirement.

> **Requirement 2:** A specialty must be a distinct and well-defined field which requires unique knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.

The Council believed that the application presented a comprehensive analysis of the distinction between the knowledge and skills possessed by a dental school graduate versus the knowledge and skills possessed by the oral and maxillofacial radiologist. The comparisons presented in the application were well-delineated and, in the Council's judgment, clearly documented that oral and maxillofacial radiology is a distinct and well-defined field which requires knowledge and skills beyond those commonly possessed by dental school graduates. For these reasons, the Council concluded that the AAOMR demonstrated compliance with this requirement.

> **Requirement 3:** The scope of the specialty: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; and (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.

The application compared and contrasted the accreditation standards of each of the recognized dental specialties with the advanced knowledge required for the practice of oral and maxillofacial radiology. The Council believed that the information contained in the application demonstrated that the body of knowledge and skills of the oral and maxillofacial radiologist as it pertains to the scope of oral and maxillofacial radiology are broader than those found in any single recognized dental specialty or combination of recognized dental specialties. In the Council's judgment, the information presented in the application indicates that there is overlap between the proposed specialty and some existing specialties; the greatest overlap occurs with oral and maxillofacial pathology. However, the Council also believed that the application presented evidence to demonstrate that while each recognized dental specialty has some level of knowledge and skill in radiology, there is no single specialty or group of specialties that could, through minimal modification, accommodate the full scope of oral and maxillofacial radiology as described in the application.

Based on its review of all information contained in this section of the application, the Council believed that the AAOMR demonstrated compliance with this requirement.

> **Requirement 4:** In order to be recognized as a specialty, substantial public need and demand for services which are not adequately met by general practitioners or dental specialists must be documented.

In response to the request for epidemiological data to support compliance with this requirement, the application included a listing of conditions diagnosed by oral and maxillofacial radiologists. These included evaluation of edentulous alveolar bone for dental implant prosthesis, imaging evaluations in temporomandibular disorders, evaluation of central osseous pathoses affecting the jaws and adjacent anatomy and evaluation of trauma affecting the jaws and adjacent anatomy. The application provided information concerning the prevalence of these conditions. The AAOMR translated disease entities into need and demand for the services provided by the proposed specialty. In the Council's judgment, the information in the application presented sufficient evidence regarding the incidence and/or prevalence of conditions diagnosed or treated by the oral and maxillofacial radiologist to conclude that there was substantial

public need for the services provided by the proposed specialty.

The application reflected that 132 dentists with professional training in oral and maxillofacial radiology devote full time to the practice of the proposed specialty. Advances in science and technology in oral and maxillofacial radiology, such as imaging techniques and recognition patterns, computerized tomography, magnetic resonance imaging, digital subtraction radiology, digital enhancements, nuclear medicine interpretations and other technologies, further substantiate the need for the specialty. Accordingly, the Council determined that the AAOMR demonstrated compliance with this requirement.

> **Requirement 5:** A specialty must directly benefit some aspect of clinical patient care.

The application documented that oral and maxillofacial radiology services are offered in a variety of settings, including radiology departments of dental schools, medical schools and hospitals; related departments within dental schools; individual dental practices devoted solely or partially to radiology referral services; and group practices with staff personnel who have advanced training in oral and maxillofacial radiology. Based on the information contained in this section of the application, the Council also noted that the practice carried on by oral and maxillofacial radiologists is conducted primarily in the institutional setting. However, the Council determined that the AAOMR had demonstrated that the proposed special area of practice directly benefits clinical patient care. Therefore, the Council concluded that the AAOMR had demonstrated compliance with this requirement.

> **Requirement 6:** Formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* must exist to provide the special knowledge and skills required for the practice of the specialty.

The application included information about nine dental schools (including two Canadian schools) that currently sponsor formal advanced education programs in oral and maxillofacial radiology of at least two years beyond the predoctoral curriculum. Additionally, letters from the chief executive officers of each institution verifying the sponsorship of these programs were provided in the application. The total number of applicants per year for all programs averages around 15; the total number of graduates each year from all programs averages from four to six. According to the information presented in the application, one program, implemented in 1993, has never graduated any students. The Council determined that the application documented that advanced education programs exist that are at least two years beyond the predoctoral curriculum. In reviewing this section of the application, the Council expressed concern that the total number of students who graduate annually in the proposed specialty is minimal.

The application included sample curricula. The Council concluded that the curricula provided in the application support the advanced knowledge and skills described elsewhere in the application.

The Council concluded that, based on information contained in this section of the application, the AAOMR had demonstrated compliance with this requirement.

Summary. Following careful review of the application for recognition of oral and maxillofacial radiology as a dental specialty, the Council determined that:

- The AAOMR has *demonstrated* that oral and maxillofacial radiology is represented by a sponsoring organization: (a) whose membership is reflective of the special area of dental practice; and (b) that demonstrates the ability to establish a certifying board.
- The AAOMR has *demonstrated* that oral and maxillofacial radiology is a distinct and well-defined field which requires knowledge and skills beyond those commonly possessed by dental school graduates as defined by the predoctoral accreditation standards.
- The AAOMR has *demonstrated* that the scope of oral and maxillofacial radiology: (a) is separate and distinct from any recognized specialty or combination of recognized specialties; and (b) cannot be accommodated through minimal modification of a recognized specialty or combination of recognized specialties.
- The AAOMR has *demonstrated* substantial public need and demand for oral and maxillofacial radiology services which are not adequately met by general practitioners or dental specialists.
- The AAOMR has *demonstrated* that oral and maxillofacial radiology directly benefits some aspect of clinical care.
- The AAOMR has *demonstrated* that formal advanced education programs of at least two years beyond the predoctoral curriculum as defined by the Commission on Dental Accreditation's *Standards for Advanced Specialty Education Programs* exist to provide the special knowledge and skills required for practice of the specialty.

For these reasons, the Council approved the following resolution for transmittal to the Association's 1996 House of Delegates.

19. Resolved, that the American Academy of Oral and Maxillofacial Radiology's request for the recognition of oral and maxillofacial radiology as a dental specialty be approved.

Advanced Dental Education

Annual Meeting of Specialty Certifying Boards: The Council hosted a meeting of the recognized dental specialty certifying boards in August 1995, during which representatives of each of the eight recognized dental specialty certifying boards participated. The meeting included a presentation on examination grading processes and examiner subjectivity. A subcommittee composed of members from the specialty certifying boards presented a report regarding enhancing relationships between boards and parent organizations. Further, discussion topics of mutual interest were identified by each participating board and presented for group discussion. Topics included: experience requirements

and current activities related to application for board eligibility; the extent of reporting test results and returning materials to candidates participating in examinations; recertification protocol of each of the boards; methods for encouraging specialists to become diplomates; issues related to the Commission on Dental Accreditation's advanced education standard 6 regarding advanced placement; legal issues relative to the appeals process for failed candidates; board executives' qualifications; and providing post-test forums after board examinations.

Meeting participants determined that board examiner objectivity and information regarding the Americans with Disabilities Act will be discussed at the summer 1996 meeting.

Allied Dental Education

Study of Allied Personnel Roles and Responsibilities: The Advisory Committee for the Comprehensive Study of Allied Dental Personnel Roles and Responsibilities was appointed by the Board of Trustees in 1993 as an advisory committee to the Council. The Advisory Committee studied major changes that are likely to impact the dental profession and the allied personnel needed to support dental practice in the future. The committee's report and recommendations were considered at the Council's April 1995 meeting. As previously reported to the House (*Reports* 1995:72), the Council noted the lack of consensus within the profession regarding some aspects of the report and recommended that another committee be appointed to review the report further, modify it as appropriate and report its recommendations to the Council and the Board.

Accordingly, a committee was appointed that included members of CDE, the Council on Dental Practice and the Board. The committee met in August 1995 to consider allied personnel issues and how the profession's goals can best be accomplished, as well as to identify appropriate revisions to the allied personnel study report. The committee's recommendations regarding the report were considered at the Council's October 1995 meeting. The Council unanimously adopted a recommendation to the Board that no further action be taken regarding the allied dental personnel study. Based on the Council's recommendation, the Board agreed to discontinue the study. However, the Board recognized the need for further discussion on the subject of allied personnel and therefore directed that the issue of utilization of allied dental personnel be a specific agenda item for the Association's Strategic Planning Committee. The background data developed by the advisory committee was referred to the Strategic Planning Committee for its review.

Nationwide Survey of Dental Assisting Programs: Resolution 89H-1994 (*Trans.*1994:614) directed that a nationwide survey be conducted to gather information on all dental assisting training programs in the United States in order to identify the total potential pool of training opportunities. As reported to the 1995 House (*Reports* 1995:77), the Association's Survey Center conducted a three-phase survey to obtain information related to the programs' enrollments, placement rates and recruitment efforts.

The Council reviewed the collected data at its April 1996 meeting. Based on the survey results, the Council directed that state dental associations be provided with the names and addresses of those survey respondents who requested assistance and that state associations be urged to encourage their members to contact these programs. The Council also directed that the Commission on Dental Accreditation be requested to provide the nonaccredited programs with information on the accreditation process. Further, the Council directed that the high school-level programs and Commission-accredited postsecondary programs be encouraged to pursue articulation agreements.

Licensure

Compliance with ADA/AADE Examination Guidelines: Resolution 93H-1992 (*Trans.*1992:629) urged all dental licensing jurisdictions to follow the ADA/AADE Guidelines for Valid and Reliable Dental Licensure Clinical Examinations. The House also directed the Council to monitor the extent to which the Guidelines were being followed by the 23 testing agencies then in existence and to report annually to the House.

Beginning in 1994, the Council distributed a questionnaire to the testing agencies, which contained a checklist of the key elements in the Guidelines, and asked each agency to indicate the elements included in its examination process and content. The purpose was to establish a baseline, so that progress could be tracked from year to year.

By 1994, a number of unaligned states had joined the regional testing agencies, so that the checklist was sent to 18 state and regional agencies. Responses were received from the four regionals plus 11 states. In 1995, the same checklist was sent out to 17 agencies, with responses received from four regionals and ten states (*Reports* 1994:76; 1995:73). In spring 1996, the checklist was again sent to the 15 current regional and unaligned state agencies. The responses from four regional and 11 state agencies are reported as follows.

Section 1. Section 1 of the Guidelines deals with candidate test information and related procedures. The 15 respondents in 1996 indicated that all have written information available for candidates related to eligibility requirements and application procedures as suggested by the Guidelines, including the patients and materials required for the examinations. A few agencies provide some of the information in separate mailings to candidates. In general, the level of compliance with Section 1 is very high among the agencies.

Section 2. Section 2 of the Guidelines is the "minimum common core of test requirements," or test content section. This section is intended to help agencies ensure the content validity of the examination, as well as to encourage greater standardization of examination content. The responses of the 15 agencies in 1996 demonstrate universal compliance in requiring a Class II amalgam restoration on a patient as recommended by the Guidelines. Nine agencies require a class III or IV anterior composite resin, while seven agencies require a cast gold restoration (preparation only in two cases). There is slightly less conformance with other aspects of the minimum common core of test requirements, although compliance appears to be increasing.

Section 3. Section 3 outlines the examiner information and training needed to enhance the reliability of the examination process. Most of the 15 agencies reported having many of the recommended items in place. For example, 11 agencies reported having defined criteria and a process for selecting examiners, while 14 indicated they have examiner training and formal calibration. Fourteen agencies indicated that they have an examiners' manual or information, and most of these include general and procedural guidelines. The compliance level related to examiner selection and communication is somewhat higher than for examination content and has shown recent improvement, especially in terms of examiner training, calibration and performance assessment.

Progress Report on the Pregraduation Examination Pilot Project: In spring 1995, the Southern Regional Testing Agency (SRTA) conducted a pregraduation clinical licensure examination at the University of Tennessee. The success of this experiment was reported at the Council on Dental Education's Open Forum on Licensure at the ADA annual session in fall 1995. To determine whether pregraduation examinations would prove feasible and desirable for other testing agencies, the Council on Dental Education encouraged several regional testing agencies to emulate the SRTA/Tennessee experiment. Three regional agencies agreed to conduct pregraduation examinations in spring 1996. The Council determined that it would conduct a formal evaluation of the examinations administered by the three regional agencies at the following four test sites:

- Northeast Regional Board of Dental Examiners (NERB) at Case Western Reserve University and Ohio State University;
- Western Regional Examining Board (WREB) at University of Texas Health Science Center at San Antonio; and
- SRTA at Medical College of Virginia, Virginia Commonwealth University.

As part of the evaluation project, the Council developed questionnaires to be completed by the candidates, dental school faculty and administrators, and examiners at each site. In addition, focus groups were conducted for candidates at each test site to obtain their perspectives on the examination experience. This integrated approach to data analysis combined the strengths of statistically representative sampling with the qualitative insights gained from individual experiences. A consultant from the Center for Educational Research and Development at the University of Texas Health Science Center at San Antonio was engaged to design the questionnaires and focus group protocols. A report of the consultant's data analysis and evaluation will be reviewed at the Council's July 1996 meeting, prior to dissemination to the Board and the examining and education communities.

Continuing Dental Education

Report of the ADA Continuing Education Recognition Program Policy Board: Currently, the Association's Continuing Education Recognition Program (ADA CERP) has recognized 285 continuing education providers. Nearly 60% of the ADA constituent dental societies and 90% of the dental schools have been recognized to date. Based on program growth, as projected in the original program proposal to the 1992 House (*Trans.*1992:613), the CERP Policy Board revised the application and annual fees to reduce the overall costs of CERP recognition for recognized providers, effective in 1997.

As previously reported to the House (*Reports* 1995:74), in March 1995 the Policy Board directed the development of a proposal for an "umbrella" form of approval to allow for recognition of certain affiliate organizations by CERP-recognized governing organizations or their constituents. At its March 1996 meeting, the Policy Board endorsed guidelines and implementation procedures for an extended approval process, through which CERP-recognized ADA constituent societies can extend approval to their component societies that offer CE primarily to their own members. Instructions and resource materials have been distributed to the CERP-recognized constituent societies. Representatives of the other CERP governing organizations have been encouraged to provide information about their organizations' structures and specific requirements, so that a similar extended approval process may be developed or adapted to suit their needs.

In order to protect the ADA CERP mark from unauthorized and inappropriate use, the ADA has filed to register ADA CERP and the logo as a service mark. Additionally, a licensing agreement for authorized use of the mark is being developed. Recognized providers will be requested to sign this agreement as part of the application process.

In January 1996, the list of ADA CERP-recognized providers was added to *ADA ONLINE* and is accessible via ADA's home page on the World Wide Web. Many recognized providers have web sites of their own. In the near future, it is anticipated that addresses can be added to allow users to "hot key" from the list on *ADA ONLINE* to a provider's own World Wide Web page.

A three-member Special Board Committee on CERP was appointed in 1994 by the Board of Trustees to review CERP's progress. The Special Board Committee on CERP has reviewed the ADA CERP committees' position within the ADA organizational structure, as directed by Resolution 133H-1995 (*Trans.*1995:646). The CERP Policy Board has also discussed the need to address potential changes in the composition of the Policy Board that may arise in the future. The Policy Board has sought the input of the Special Board Committee on CERP and the Board of Trustees regarding these issues.

Canadian Participation in ADA CERP: Since the spring of 1995, ADA CERP has explored opportunities to involve the Canadian Dental Association (CDA) in marketing ADA CERP to Canadian continuing education (CE) providers. As a result, the CDA has sought a participatory role in the ADA evaluation process, rather than developing a separate process for Canadian CE providers.

For its part, the CDA has offered to endorse ADA CERP to Canadian providers and to encourage participation in Canada. Further, by encouraging provincial licensing bodies to accept ADA CERP approval, CDA would enhance the value of the program for U.S.-based recognized providers and for member dentists in both countries.

At its March 1996 meeting, the Policy Board considered a draft agreement and approved the proposed participation by

the CDA in ADA CERP. The Policy Board directed that an appropriate resolution to implement the ADA/CDA agreement be forwarded to the ADA Board of Trustees and, with the concurrence of the Board, to the 1996 House of Delegates. Under the agreement, a CDA representative would be added to the Policy Board and the Review Committee. It is believed that revenues from additional Canadian participants would offset the costs associated with adding a Canadian representative to the CERP committees.

On the Canadian side, the agreement will require approval by the CDA Committee on Continuing Education, the Council on Education and the Board of Governors, which meets in August 1996. Upon approval of the agreement, marketing activities could be initiated immediately, with an implementation date of January 1997.

Dental Admission Testing Program

Dental Admission Testing Program (DAT) Trends: The number of candidates participating in the DAT Program has been increasing by approximately 13% annually during the most recent five-year period. The total number of candidates participating in the testing program during 1995 was 10,271. This is an increase of 10.2% from the previous year (9,324). During this period of annual increases, the percentages of males and females participating in the testing program have remained relatively stable at approximately 63% and 37%, respectively. There have been changes in the ethnic distribution of the cohorts participating in the program during this period, however. The percentage of candidates identifying themselves as Asian has gradually increased from 19% in 1991 to 26% in 1995. These annual increases are being largely offset by decreases in the percentage of white candidates; the percentage of white candidates has declined from 67% in 1991 to 57% in 1995. The percentages of Native American, black and Hispanic candidates have remained relatively stable during this period. During 1995, 1% of candidates were Native American, 5% were black and 5% were Hispanic. Six percent of candidates did not specify their race or ethnic identity.

The performance of candidates across test administrations shows little change. Candidate performance over the most recent five years tends to be increasing, but these increases are slight and of little practical significance. The performance of dental students accepted during the same period also is stable. Further, there is little difference between the performance of those individuals participating in the testing program and those matriculating in dental school. This suggests that while the pool of individuals participating in the testing program is expanding, dental schools continue to select applicants with a full range of abilities as measured by the test.

Dental Admission Testing Program Development and Research Activities: Increasingly, national testing agencies are converting from the print to the computer medium to deliver their testing materials. There are essentially two forms of computer-based tests (CBT). One form delivers a fixed set of multiple-choice items to candidates on a computer while the other form, known as computer-adaptive testing, delivers an individualized set of items to each candidate depending on the candidate's abilities. There are many advantages associated with the use of CBT. To name a few, it allows for increasing test security and for providing test results immediately. A pilot administration of a computer-based DAT is planned for July and August of 1996. The purpose of this pilot is to determine whether CBT is an appropriate medium for delivering the DAT. If the pilot proves to be successful, then the DAT will be delivered both in print and on computer during 1997. Then, beginning in 1998, the print version of the DAT would be discontinued.

During 1996 and 1997, the testing program will develop, pilot and conduct validity research on a test designed for possible use in the dental hygiene program admission process. This pilot is in response to the expressed interest of program directors. It is anticipated that a dental hygiene admission test would provide dental hygiene program admission committees with the use of a single, nationally standardized instrument designed to evaluate those abilities important for success in a dental hygiene education program. Further, the appropriate use of such a test would enable program directors to select those applicants who are most likely to succeed in the program. This should result in a more effective educational experience for the student and more consistent quality in the pool of new dental hygienists entering the field. Reduced attrition rates in educational programs could be expected, which would mean more students graduating.

Ongoing research on the DAT is being conducted in a number of areas. The first area is related to the annual validation of the DAT in predicting performance in dental school didactic and technique courses. The results of this research indicate that the academic portion of the DAT continues to be the best single predictor of the first- and second-year dental school didactic grades and that the Perceptual Ability Test (PAT) is the best single, nationally available predictor of technique performance.

The second area of ongoing research also is related to test validity issues. The emphasis of this research, however, is the development of guidelines for the construction of PAT and reading comprehension test items. Research on the PAT is focusing attention on those characteristics of PAT items that tend to enhance the validity of the PAT in the prediction of performance. Research devoted to the identification of design features is valuable for the development of items that exhibit psychometric characteristics that are appropriate for admission tests. The research relevant to reading comprehension is examining the relationship of item difficulties to reading passages in light of cognitive processing models. Findings of this research should allow for development of such passages appropriate to the DAT. Finally, research that focuses on equating will be conducted during 1996 and 1997. Equating is used by large-scale testing programs to ensure that test results from different administrations of the test have the same meaning or interpretation. Traditionally, equating is accomplished using common items that appear on different editions of the test. Studies will be conducted to determine the efficiency of equating through common constructs rather than items.

The final area of ongoing research activity is related to the test items that exhibit performance differences that may be related to candidates' gender and ethnicity. Research in this area is designed to identify problematic items, i.e., items that evaluate content that is differentially familiar to groups of candidates. These items are then reviewed and revised by test

construction committees. Research findings clearly show that the items on the DAT are not differentially familiar to any particular group of candidates. As such, the DAT provides unbiased estimates of candidates' achievements and abilities.

Research on alternate formats begins in 1996. At the present time, the DAT employs only multiple-choice type items to evaluate candidate achievement. The purpose of this research effort will be to determine whether other test formats (e.g., free-response items) are superior to multiple-choice items in evaluating achievement and in predicting dental-school performance.

Response to Assignments from the 1995 House of Delegates

Revision of Policy on Number of Areas of Dental Practice: Resolution 8H-1995 (*Trans.*1995:633) updated the Association's policy regarding the number of areas of dental practice. This revised policy will be included in the next edition of *Current Policies*.

Evaluation of Dental Curricula Relating to Instruction in Geriatric Dentistry: Resolution 21-1995 (*Trans.*1995:633) was referred by the House of Delegates to the Council on Dental Education to develop an action plan with cost implications, in conjunction with other agencies, to address the issue of training dentists to meet the dental needs of the geriatric population. The Council reviewed preliminary data showing that almost 90% of dental schools provided course work in geriatric dentistry and almost 75% of dental schools required clinical experience in geriatric dentistry. The Council considered adding questions to the annual survey to gather additional data about geriatric dentistry instruction and clinical experience; such an action would have no cost implications. The Council referred the issue of adding questions about geriatric dentistry instruction on the Annual Survey of Dental Educational Institutions to the ADA/AADS Liaison Committee for further consideration. The Council also provided a report of its plan to the Council on Access, Prevention and Interprofessional Relations, since Resolution 21 originated from a report generated in conjunction with that agency.

Admission Criteria for Dental Hygiene Students: In response to Resolution 60H-1995 (*Trans.*1995:639), correspondence has been sent to all communities of interest encouraging support for its intent. In addition, the Commission on Dental Accreditation noted that the meaning of this resolution is consistent with its Accreditation Standards for Dental Hygiene Education Programs.

Redesignation of the Specialty of "Oral Pathology" to "Oral and Maxillofacial Pathology": In response to Resolution 67H-1995 (*Trans.*1995:632), the American Academy of Oral and Maxillofacial Pathology was notified of the resolution adopted by the 1995 House approving the redesignation of the specialty. Further, as directed in the resolution, ADA documents and policies have been amended to reflect the change. Additionally, the communities of interest have been advised of the change in designation and have been encouraged to utilize the new designation when referring to the specialty.

Revision of the *Requirements for Recognition of Dental Specialties and National Certifying Boards for Dental Specialists*: In response to Resolution 68H-1995 (*Trans.*1995:633), the recognized dental specialty organizations were provided with a copy of the revised *Requirements*. In addition, the communities of interest have been advised of the availability of the revised *Requirements*. Further, the specialty recognition application materials have been updated to reflect the changes in the *Requirements*.

Credentialing for Dental Assistants: In response to Resolution 69H-1995 (*Trans.*1995:634), the Council has communicated this action to the dental assisting communities of interest, as well as to constituent and component dental societies.

Implementation of Recommendations Contained in the Institute of Medicine Report: In response to Resolution 91H-1995 (*Trans.*1995:643), a copy of the resolution has been sent to constituent dental societies, state dental boards, recognized dental specialty organizations and certifying boards, national dental organizations and dental deans. Additionally, this resolution was reviewed by the ADA's Special Board Committee to Study the IOM Report. The Special Board Committee's report will be presented to the Board for consideration at its June 1996 meeting for transmission to the 1996 House.

Dentistry as an Independent Profession: In response to Resolution 98H-1995 (*Trans.*1995:640), correspondence has been sent to constituent dental societies, state dental boards, recognized dental specialty organizations and certifying boards, national dental organizations and dental deans advising them of the adoption of this policy statement.

Mission of a Dental School: In response to Resolution 99H-1995 (*Trans.*1995:640), correspondence has been sent to all dental deans advising them of the adoption of this policy statement.

Development of a Curriculum to Reflect Dental Practice: In response to Resolution 104H-1995 (*Trans.*1995:642), which stated the Association's belief that dental school graduates must be competent to evaluate the advantages and disadvantages of different models of oral health care management and delivery and that instruction related to the traditional private practice fee-for-service model should be included, the Council forwarded to all dental school deans a copy of the resolution and urged that they take appropriate steps to implement the instruction.

Elimination of Programs which Integrate Dentistry into Medicine: Resolution 105-1995 (*Trans.*1995:643) was referred by the House of Delegates to the Council on Dental Education and the Special Board Committee to Review the IOM Report for study. In referring this issue to the Council, the House noted that the matter was currently being studied by the Council in response to an April 1995 request from the Board. The resolution directed the Council to work with appropriate groups to eliminate any programs that integrate dentistry into medicine. In conjunction with its study of this issue, the Council collected and reviewed data related to

dental education programs that led to both the MD degree and the DDS or DMD degree.

Although four dental schools reported having MD-DDS/DMD programs in place in their annual surveys, three of the schools indicated, in response to the information request and subsequent interviews, that they did not have a combined MD-DDS/DMD program, but had a specialty certificate/MD program. The fourth school indicated that a program was in place but that none of the students enrolled in both programs had ever graduated from both, eventually dropping out of one or the other. One school that is planning a pilot project for an MD/DMD program is still in the early development phase; no curriculum exists and no students have been accepted. It was reported that the pilot project could not be operational before the summer of 1997, if then. No other schools reported a combined degree program. The Council directed that the data collected regarding the availability of programs leading to both the MD and DDS/DMD degrees be shared with the Special Board Committee to Review the IOM Report and the Board of Trustees, noting that there is no evidence to indicate any trend to develop such programs.

Review of the Association's Continuing Education Recognition Program (ADA CERP): In response to Resolution 133H-1995 (*Trans.*1995:646), the Board of Trustees directed the Special Board Committee on CERP to review the structure and function of the ADA CERP committees and to make a recommendation as to the feasibility of making the ADA CERP a function of the Council on Dental Education. On several occasions, the Special Board Committee on CERP has considered the ADA CERP committees' position within the Association's organizational structure. This committee will consider this matter further in June and forward any resulting recommendations to the Board.

Recommendations for Policy Rescissions: In response to Resolution 15H-1995 (*Trans.*1995:660), the Council on Dental Education reviewed current Association policies to determine whether any redundancies or irrelevancies existed. Based on this review, the Council adopted the following recommendations.

Prosthodontic Training and Examination. The Guidelines for Valid and Reliable Dental Licensure Clinical Examinations includes recommended removable prosthodontics components for licensure examinations; this policy is redundant. The Council, therefore, recommends adoption of the following resolution.

20. Resolved, that Resolution 7H-1977 (*Trans.*1977:937), Prosthodontic Training and Examination, be rescinded.

Expansion of SELECT Program to Include All Dental Auxiliaries. The SELECT Program was discontinued in 1994 and its activities were transferred to the Department of Career Guidance. The Council, therefore, recommends adoption of the following resolution.

21. Resolved, that Resolution 48H-1988 (*Trans.*1988:496), Expansion of SELECT Program to Include All Dental Auxiliaries, be rescinded.

Program for Dental Auxiliary Utilization in the Veterans Administration. The Veterans Administration's Program for Dental Auxiliary Utilization no longer exists; this policy is no longer applicable. The Council, therefore, recommends adoption of the following resolution.

22. Resolved, that Resolution 61H-1986 (*Trans.*1986:528), Program for Dental Auxiliary Utilization in the Veterans Administration, be rescinded.

Licensure Policies. The following policies have already been incorporated into the Guidelines for Licensure policy, which was revised in 1992 (*Trans.*1992:632). The Council, therefore, recommends adoption of the following resolution.

23. Resolved, that the following resolutions be rescinded:

Resolution 33H-1989 (*Trans.*1989:526), Consideration of New Methods for Determining Current Clinical Competence;

Resolution 32H-1976 (*Trans.*1976:921), Relicensure by Credentials;

Resolution 25H-1976 (*Trans.*1976:915), Purpose of Licensure;

Resolution 50-1971-H (*Trans.*1971:531), Criteria Approval Provisions for Licensure; and

Resolution 7-1968-H (*Trans.*1968:250), Dental Society Consultation Regarding Licensure.

State Dental Board Use of Term "Oral and Maxillofacial Surgery." The term oral and maxillofacial surgery has been utilized for nearly 20 years. The Council, therefore, recommends adoption of the following resolution.

24. Resolved, that Resolution 15H-1978 (*Trans.*1978:518), State Dental Board Use of Term "Oral and Maxillofacial Surgery," be rescinded.

The Commission on Dental Accreditation will review Association policies related to accreditation in July 1996. Any identified redundancies or irrelevancies will be reported to the House of Delegates with relevant recommendations.

Summary of Resolutions

19. Resolved, that the American Academy of Oral and Maxillofacial Radiology's request for the recognition of oral and maxillofacial radiology as a dental specialty be approved.

20. Resolved, that Resolution 7H-1977 (*Trans.*1977:937), Prosthodontic Training and Examination, be rescinded.

21. Resolved, that Resolution 48H-1988 (*Trans.*1988:496), Expansion of SELECT Program to Include All Dental Auxiliaries, be rescinded.

22. Resolved, that Resolution 61H-1986 (*Trans.*1986:528), Program for Dental Auxiliary Utilization in the Veterans Administration, be rescinded.

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Resolution 33H-1989 (*Trans.*1989:526), Consideration of New Methods for Determining Current Clinical Competence;

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Resolution 50-1971-H (*Trans.*1971:531), Criteria Approval Provisions for Licensure; and

Resolution 7-1968-H (*Trans.*1968:250), Dental Society Consultation Regarding Licensure.

24. Resolved, that Resolution 15H-1978 (*Trans.*1978:518), State Dental Board Use of Term "Oral and Maxillofacial Surgery," be rescinded.

Joint Commission on National Dental Examinations

Legler, Donald W., Illinois, 1996, chairman, American Association of Dental Schools
Zais, Martin H., Hawaii, 1996, vice chairman, American Association of Dental Examiners
Clagett, Dan Ray, Kentucky, 1998, American Association of Dental Examiners
Cole, James R., II, New Mexico, 1997, American Association of Dental Examiners
Eisner, John E., New York, 1997, American Association of Dental Schools
Fetsch, Michael F., Indiana, 1998, public representative
Fortman, Jared R., Missouri, 1996, American Student Dental Association
Franklin, Sanford M., Ohio, 1999, American Dental Association
Johnson, Jane A., West Virginia, 1998, American Dental Association
Kalkwarf, Kenneth L., Texas, 1999, American Association of Dental Schools
Kelly, Kathleen A., Wisconsin, 1997, American Association of Dental Examiners
Liberto, Vincent N., Louisiana, 1999, American Association of Dental Examiners
Wilbanks, John D., Texas, 1997, American Dental Association
Wyman, Ross G., Maine, 1999, American Association of Dental Examiners
Zarkowski, Pamela, Michigan, 1998, American Dental Hygienists' Association
DeMarais, David R., director, Department of Testing Services

The Strategic Plan of the American Dental Association: The primary objective of the Joint Commission on National Dental Examinations (JCNDE) is to provide high quality and state-of-the-art National Board Dental and Dental Hygiene Examinations. In this way the JCNDE supports the Association's Strategic Plan by: furthering the Association's commitment to quality dental care; promoting excellence and consistency in the education and evaluation of the dental team members; providing a uniform written licensure examination; working with other dental organizations in a collegial relationship; and providing nondues revenues to support its programs.

Meetings: The JCNDE met in the Headquarters Building, Chicago, on March 13, 1996. Most of the topics considered by the JCNDE were initially reviewed by one of three committees. The Committees on Administration, Dental Hygiene and Examination Development met on the afternoon of March 12.

The Annual National Dental Examiners' Advisory Forum, sponsored by the JCNDE, met in Chicago on the morning of March 12. Approximately 80 state board representatives and dental educators from approximately 40 states attended the Forum. The program addressed various aspects of the National Board Dental and Dental Hygiene Examinations: history and rationale, examination structure, pass/fail trends and results from the pilot case-based dental hygiene examination.

During the year, 23 test construction committees were held to develop new editions of National Board Dental and Dental Hygiene Examinations. A committee also met to study the need for additional research and development activities relative to the examinations.

Acknowledgments: The JCNDE acknowledges with appreciation the contributions made by Dr. Donald W. Legler, Mr. Jared R. Fortman, Dr. Sara Sue Sturgeon and Dr. Martin H. Zais, who complete their service on the Joint Commission this year.

Trends in Numbers of Test Candidates and Pass Rates:

National Board Dental Hygiene Examination. The numbers of candidates taking the dental hygiene examination in 1993, 1994 and 1995 remained stable at slightly more than 5,000 (5,161, 5,006 and 5,094 respectively). Performance on the examination was also stable during these years with pass rates of 94% each year.

National Board Dental Examinations, Part I. The number of Part I candidates in 1995 (6,655) was the highest in the past ten years. Of this total, the number of U.S.-trained candidates (4,629) was the highest since 1986, while the number of Part I candidates who graduated from nonaccredited dental schools was the highest on record (2,026).

Part I performance of U.S.-trained candidates was stable over the past three years with pass rates of 86%. Part I performance of graduates of nonaccredited dental schools, however, declined from a pass rate of 49% in 1993 to 43% in 1994 and 1995.

National Board Dental Examinations, Part II. The number of Part II candidates in 1995 (5,649) was the highest since 1986. Of this total, the number of U.S.-trained candidates (4,550) was the highest since 1989, while the number of Part II candidates who graduated from nonaccredited dental schools (1,099) has remained relatively stable for the past six years.

Part II performance of U.S.-trained candidates, which had improved to a pass rate of 87% in 1994, dropped in 1995 to a pass rate of 81%. Part II performance of candidates from nonaccredited dental schools also dropped, from a 50% pass rate in 1994 to a pass rate of only 40% in 1995.

Pass Rates of Repeating Candidates. In 1995, the pass rates of repeating candidates (those who had failed previously) were compared with first-time candidates' rates. In all cases, the repeating candidates had pass rates significantly lower than first-time candidates. U.S.-trained Part I candidates who were taking the examination for the first time had a pass rate of 89%, while repeating U.S.-trained candidates had a pass rate of only 65%. U.S.-trained Part II candidates who were taking the examination for the first time had a pass rate of 86%, while repeating U.S.-trained candidates had a pass rate of only 51%.

Graduates of nonaccredited dental schools who were taking Part I for the first time had a pass rate of 51%, while repeating candidates from nonaccredited schools had a pass rate of only 32%. Part II candidates from nonaccredited schools who were taking the examination for the first time had a pass rate of 54%, while candidates from nonaccredited schools who were repeating the examination had a pass rate of only 23%.

Repeating dental hygiene candidates also had pass rates significantly lower than first-time candidates. In 1995, the repeating dental hygiene candidates had a pass rate of only 60%, while the pass rate for first-time candidates was 96%.

Selection of Test Constructors for National Board Examinations: Each year the JCNDE communicates with constituent dental societies, dental schools and state boards of dentistry requesting applications for new test constructors to fill vacancies on a rotating basis. During its recent meeting, the JCNDE selected 15 new dental test constructors and five new dental hygiene test constructors. The JCNDE also reappointed 61 dental test constructors and 13 dental hygiene test constructors to another one-year term.

Pilot of Case-Based National Board Dental Hygiene Examination: In February 1996, virtually every accredited dental hygiene educational program participated in a pilot of a new format for the dental hygiene examination. The pilot comprised a component with "stand-alone" test items in the traditional format and a component of test items based on eight dental hygiene patient cases. The pilot was the last step in a feasibility study initiated by the JCNDE in 1993.

The results of the pilot indicated that the new format contained a valid representation of subject matter taught in the accredited programs; was more clinically relevant than the traditional format; suggested that higher cognitive behaviors were assessed by the case-based items; provided a highly reliable examination; resulted in a unidimensional test, the results of which may be reported by means of one score; and suggested that the case-based part of the test will not be more difficult for students than the traditional format.

The JCNDE approved the immediate development of new dental hygiene examinations according to the case-based format. These new examinations will be administered for the first time in 1998 and will be scored by means of the criterion-referenced method using the Rasch psychometric model.

New Research and Development Program for National Board Examinations: In 1994, the JCNDE initiated a study of the unmet research and development needs of the National Board Examinations. A preliminary report on this matter was reviewed in 1995 and a final report in 1996. The final report, prepared by JCNDE members and outside psychometricians, was complimentary of the high quality of existing examinations and recent research and developmental activities related to both the dental and dental hygiene examinations. However, proposals recommending new research and development activities were supported by the JCNDE in order to ensure state-of-the-art testing methods. These included: establishing a new subcommittee to monitor future research and development activities, developing a technical manual from current statistical reports, performing a task analysis to enhance the basis for test validity, increasing efforts to enlarge test item pools, conducting a literature review on alternative testing formats, and increasing candidate fees to support additional research activities.

Continuation of Support for the Dental Interactive Simulations Corporation (DISC): During its March 1996 meeting, the JCNDE discussed its financial support of DISC and whether or not to continue the candidate assessments that are the source of these funds. An optimistic report was received from the JCNDE representative to DISC which outlined recent progress in the development of a DISC simulation demo as well as a four-phase strategic plan for product development adopted by DISC. The JCNDE enthusiastically supported continuation of its financial support for DISC, but it was unanimous in directing its representative to support establishing DISC policy that will ensure JCNDE access to the DISC product without additional costs.

Assistance to Other Agencies: One of the duties of the JCNDE is to serve as a resource for the dental profession for written examinations. During the past year, staff assisted other dental organizations in developing new examinations, revising test specifications, reviewing examination procedures, scoring examinations and analyzing examination quality. This support was provided to the American Board of Endodontics, the American Board of Orthodontics, the American Board of Periodontology, the Academy of General Dentistry and the American Association of Hospital Dentists. This assistance is provided for a fee to cover costs. Special assistance is also provided to state boards of dentistry upon request.

Resolutions: This report is informational in nature and no resolutions are presented.

Notes

Division of Finance and Operations

Council on Insurance

Notes

Council on Insurance

Cain, James L., Oregon, 1996, chairman
Kennedy, W. Philip, South Carolina, 1997, vice chairman
Abelson, Sigmund H., California, 1999
Akerson, Harvey A., South Dakota, 1998
Barth, Tom L., Kansas, 1999
Butterfield, Donald E., New Mexico, 1997
Clitheroe, William R., Texas, 1997
Davidson, Joel D., Connecticut, 1997
Dixon, Mervyn J., Florida, 1998
Moon, G. Rodger, Illinois, 1999
Niedhamer, Albert C., Ohio, 1998
Orlacchio, William A., New Jersey, 1996
Piana, Anthony E., New York, 1996
Sarandria, Donald C., Pennsylvania, 1996
Stanislav, Leon E., Tennessee, 1999
Stifter, Ronald P., Wisconsin, 1998
Dwyer, David R., director

Meetings: The Council met at the Headquarters Building on August 25-26, 1995 and March 29-30, 1996. It is scheduled to meet again on August 23-24, 1996.

Vice Chairman: Dr. W. Philip Kennedy was elected vice chairman of the Council at the March 1996 meeting.

The Strategic Plan of the American Dental Association: The Council believes that the Association-sponsored insurance and retirement programs support the Strategic Plan in all applicable respects. These programs are among the most highly utilized discretionary benefits of membership. The economic advantages they offer are tangible and measurable evidence of the value of participation in organized dentistry. Thus, they support the Strategic Plan's membership recruitment and retention objectives.

The insurance and retirement programs are entirely supported by user fees. The Association is reimbursed for all costs it incurs on behalf of these programs as represented by the Council's budget. This reimbursement is factored into the insurance premiums or retirement plan fees paid by participating members. Therefore, these programs meet the financial directives of the Strategic Plan and do not require the use of membership dues.

Finally, the insurance and retirement programs add to the financial well-being of member dentists both in terms of the high quality of the products they offer as well as their very competitive costs. The ADA Members Retirement Program also responds to the Strategic Plan's call for the Association to be of real value to the dentist in financial planning for retirement. Especially for younger dentists and others building their retirement savings, the Program provides an affordable means of saving and investing for retirement on a tax-advantaged basis.

The Council will continue to manage the sponsored insurance and retirement savings programs in accordance with the objectives of the Strategic Plan and to identify additional opportunities to meet the changing needs of the membership.

Group Life Insurance Program: The Group Life Insurance Program consists of the Term Life Insurance Plan, the Term Plus Insurance Plan and the Noncontributory Life Insurance Plan for Dental Students. It is underwritten and administered by the Great-West Life & Annuity Insurance Company.

As of December 31, 1995, $20 billion of insurance was in force under the Term Life Plan, an increase of approximately 7% from 1994. There is more insurance in force under the ADA Plan than is issued by over 92% of the significant insurance companies in North America.

At year-end, 66,363 member dentists were participating in the Plan and the average amount of coverage carried per member was $266,000. In addition, 21,711 members were insuring their spouses and 11,016 were insuring their eligible, dependent children.

A total of 5,124 student members was participating in the Noncontributory Life Insurance Plan for Dental Students. This Plan offers $25,000 of term life insurance without payment of premium until July 1 of the year following the year of graduation from dental school. The expense of the Student Plan is borne by the ADA Group Life Insurance Program. In 1995, approximately 43% of the Student Plan participants who graduated in 1994 elected to continue coverage under the ADA Term Life Plan. This influx of younger members into the Term Life Plan should continue to have a positive impact on claims experience and thus benefit all insureds. It also contributes to the Association's effort to recruit new dentists as active members.

The Term Plus Insurance Plan combines life insurance protection with a tax-advantaged savings account. Participants may make premium contributions that exceed the cost of the life insurance protection and administrative fees. These excess contributions are invested in one-, three- and/or five-year fixed income accounts that provide a guaranteed rate of interest that is competitive with yields offered by major banks on certificates of deposit of comparable maturities. The money in these accounts can be left to accumulate in the policy, be withdrawn or borrowed by the insured, or used to pay future insurance costs. Under current law, federal income taxation on the interest earned by these accounts is deferred until such time as this money is withdrawn from the policy. If paid to the beneficiary as part of the death benefit, the interest escapes federal income taxation entirely.

At year-end 1995, there were 2,426 members participating in the Term Plus Plan. The average amount of coverage in force per member was $272,000 and the total volume of insurance in force rose to $660 million. Participants deposited $6,749,721 to their cash accumulation accounts in 1995, raising the Plan's total invested assets to $24.6 million.

Benefits totaling approximately $24.6 million were paid to the beneficiaries of the 365 Life Insurance Program participants who died during 1995. The deceased included 345 member dentists, two dental students, 14 spouses and four children.

Based upon the favorable financial experience of the Life Insurance Program in 1995, the Council determined that a premium credit of 30% should be applied in 1996. The Council believes that the ADA Life Insurance Program's low rates, combined with its accidental death and waiver of premium features, make it the best life insurance value available to dentists and one of the premier benefits of Association membership.

Discontinuance of Scheduled Coverage Reductions. The Council approved a proposal to permit participants in the Term Life Insurance Plan to renew the full amount of their insurance to age 75. Currently, the participants' protection is reduced by 10% at age 65. The coverage continues to reduce by 10% of the original face amount in each succeeding year until the participant attains the age of 71. At that time, the participant holds 30% of the insurance originally in force, and this coverage may be renewed until age 75.

Many members have asked to continue the full amount of their term life insurance after age 65 for a variety of reasons. Some are continuing to practice beyond age 65. Others have children who are still dependent upon them. It was the Council's judgment that these dentists should have the option to renew all of their coverage until age 75. Therefore, the Council directed that the master policy of the Term Life Plan be amended January 1, 1997 to eliminate the scheduled coverage reductions for all participants who are then under age 65.

Income Protection Plan: The Income Protection Plan is underwritten and administered by the Great-West Life & Annuity Insurance Company. It offers monthly benefits as high as $8,000 when an injury or illness prevents insured dentists from working in their special area of practice. Payments are not reduced if the dentist is able to return to work in another occupation. A residual benefit is offered as a standard coverage feature and provides continuing income when the dentist returns to work on a part-time basis. Participants may tailor their protection by selecting from a variety of coverage features. They include a choice of 30-, 90- or 180-day waiting periods. In addition, optional coverages are offered that can protect the dentist against future uninsurability, inflation's impact on the purchasing power of benefit payments or gradually developing partial disability.

As of December 31, 1995, 24,477 members were participating in the Income Protection Plan. Over 76% elected the Long-term Disability Plan that can provide for the payment of benefits to age 65 or, in some cases, for life. During the year, the trend toward longer elimination periods continued with approximately 40% of the participants electing the 90- and 180-day options, compared with 37% in the prior year. There was also continued growth in the number of participants electing the Plan's optional coverages.

During 1995, a total of $9,201,400 in benefits was paid by Great-West Life to participants who became disabled on or after November 1, 1992.

Premium Increases for Participants Having Seven- and 30-day Elimination Periods. Although the Income Protection Plan has enjoyed generally favorable claim experience, it has been adversely impacted by conditions in the financial markets. The Plan holds substantial reserves to fund future benefit payments to members who are presently disabled. These reserves are primarily invested in conservative financial assets, such as government and corporate bonds, in which yields have been declining in recent years. As a consequence, the Plan has been unable to earn the investment income anticipated by its premium structure.

Given this problem, the Council concluded that it would be necessary to either increase premiums or reduce benefit payments by restricting the Income Protection Plan's terms of coverage. It was the Council's judgment that most participants would prefer to pay higher premiums rather than to accept coverage restrictions.

An analysis of the Income Protection Plan's claim experience showed that the loss ratios of participants with short waiting periods were significantly in excess of the group as a whole. In particular, loss ratios among participants holding seven-day waiting periods, a coverage option that is no longer marketed, were particularly unfavorable. This mirrors the broader industry's experience with short-term disability insurance. As a result of the high cost of processing claims and paying benefits for short-term disabilities, most insurers have discontinued offering policies having waiting periods of less than 60 days.

Based upon the recommendations of Great-West Life's actuaries, the Council accepted a premium increase of 3% for participants having a 30-day waiting period and an increase of 15% for those having a seven-day waiting period, effective November 1, 1996. These adjustments will not apply to any optional coverages purchased by affected participants. There will also be no premium increases for the participants having the Plan's 90- and 180-day waiting period options.

The Council believes that even with these premium increases, the costs of coverage under the Income Protection Plan will remain significantly lower than those of alternative policies of comparable quality. It also notes that these premium adjustments apply to coverage that is no longer offered by most insurers and that participants can avoid these premium increases entirely by selecting the Plan's 90- and 180-day waiting period options.

Conditions in Disability Insurance Marketplace. In recent years, conditions in the disability insurance marketplace have been deteriorating. Many insurers have withdrawn from this market, and those remaining are increasing premiums and/or restricting the terms and conditions of the coverage offered. Dentists and physicians are among the occupational groups that have been identified as having particularly adverse claim experience. Some companies will no longer issue dentists their most advantageous policies and others are charging dentists their highest rates. In some cases, special underwriting restrictions are applied to dentists in certain

states. In addition, some insurers are returning to the past practice of charging higher premiums for females.

Many insurers believe that the adverse claim experience among their physician and dentist policyholders is related to economic pressures on the health care professions resulting from managed care, government regulation, etc. There is a perception that some claims, particularly those in which symptoms are difficult to verify through independent medical examinations, may be based less upon actual impairment than a desire to change occupations or retire early. In some cases, this is leading insurers to consider restricting benefits for so-called mental and nervous conditions or those in which the insured returns to work in a new occupation.

The Council is limited in its ability to evaluate the justification for the conditions taking place in the disability insurance market. It can only note that the claim experience of the Income Protection Plan does not suggest that there has been a significant increase in the frequency or severity of claims among dentists. The ADA-sponsored Plan has benefit provisions that are among the most liberal available on the market and rates that are far below those of competitors. However, its ratio of claims to premium has been relatively stable.

It is possible that conditions in the marketplace are being fueled by falling yields on insurance company investment portfolios. Like the Income Protection Plan, many insurers must respond to declining investment income by raising premiums or restricting benefits. That most insurers are taking actions far more significant than the ADA-sponsored Plan may be related to the high costs of marketing their policies. These insurers must allocate significant percentages of premium to pay agent commissions. The Income Protection Plan, by comparison, pays no commissions and is entirely marketed by mail.

The Council does not believe that conditions in the disability insurance marketplace are likely to improve significantly in the foreseeable future. It will continue to monitor the market and notify the Association's leadership of any significant changes that may occur. In the meantime, the Council continues to believe that dentists will be well-served if they take advantage of the group plans offered by dental associations.

Student Disability Insurance Plan. The Student Disability Insurance Plan was significantly enhanced in May 1994. The initial enrollment under the revised plan took place in the fall of 1994 and, by year-end, totaled 381 students. During 1995, participation increased modestly to a total of 444 students as of December 31, 1995.

The Student Disability Insurance Plan offers a choice of a monthly benefit of either $1,000 or $2,000 payable for up to two years when the student is unable to continue school because of an accident or an illness. Benefits can also be paid if the student elects to discontinue school because of an HIV-seropositive status. After the first two years, benefits can continue if the student is then totally disabled from obtaining gainful employment.

Thus far, one claim has been reported under the Student Disability Insurance Plan. It has been presented by an HIV-seropositive student, who is receiving a $2,000 monthly payment in accordance with the terms of the policy.

Students may purchase coverage under the Plan regardless of health during an annual open enrollment period. The insurance can remain in force without interruption until the first day of active practice, at which time it can be converted to the Income Protection Plan for practicing dentists. In this way, a member can be insured under an Association-sponsored disability insurance plan without interruption from the first day of dental school until the date of retirement from active practice.

At its August 1995 meeting, the Council accepted a proposal to develop an arrangement whereby entire dental schools could be enrolled under the ADA Student Disability Insurance Plan. Under this arrangement, schools in which at least 50% of the students are ADA members can enroll all of their students. Schools that take advantage of this offer can obtain the insurance at premiums that are approximately 33% lower than those charged when students enroll individually. Each student will receive an individual certificate of insurance and the cost of the coverage will be included in his or her school fees.

The dental school group enrollment arrangement was developed to respond to the needs of schools that are purchasing disability insurance under group arrangements whereby entire schools are automatically enrolled. They include the dental schools of Indiana University, the Medical College of Georgia and all of the dental schools in California.

Although the ADA Student Disability Plan was offered to schools known to be considering a group contract, it was not selected. One problem was that it could not be extended to students who were not ADA/ASDA members. Another was that it did not guarantee conversion to a long-term disability plan upon the insured's graduation unless the new dentist was an ADA member. The concern was that graduates having health problems would be left without coverage if they did not believe that they could afford to participate in organized dentistry in their initial years of practice.

The Council noted that the practice of enrolling entire dental schools in disability insurance programs that are not sponsored by the Association could be harmful to the recruitment effort in that it would eliminate one of the important benefits of membership. For this reason, the Council believes that the Association needs to be able to offer a similar arrangement to schools that wish to proceed on this basis. However, it concluded that before such an arrangement could be viable, it would be necessary to address two membership issues. Since dental schools adopting group arrangements could not discriminate against certain students on the basis of membership, it would be necessary to allow students to enroll. The Council was of the opinion that it would be reasonable to require at least 50% membership among a school's students, as this would allow the group arrangement to be available to a majority of the dental schools. Secondly, it would serve as an incentive for the remaining schools to encourage greater ADA membership among their student body.

Second, the Council needed to address the membership requirements of the Income Protection Plan under which participants in the Student Plan would be issued coverage upon graduation. The Council does not support offering coverage under the Association-sponsored insurance programs to nonmembers. However, it agreed that it would make sense to make an exception in the case of recent dental school graduates who had participated in the ADA Student Disability Insurance Plan. This would not only assure the viability of the Student Plan, but it could also contribute to the recruitment of

younger dentists as members. With each semiannual premium notice, these young dentists would see the immediate savings they could obtain by becoming members by comparing the cost of ADA-sponsored insurance with that of comparable non-group policies. These savings will be lost if they do not become members of the Association within five years. In addition to highlighting the insurance-related savings, premium notices sent to these dentists could also become vehicles for membership recruitment materials. The Council believed that this recruitment goal would be further strengthened by applying a surcharge to the Income Protection Plan's premiums. It was advised that such surcharges are permissible under Illinois Insurance Statutes but can not exceed $50 semiannually.

The Council was reluctant to recommend these arrangements to the Board of Trustees without consideration of the views of the Council on Membership. Accordingly, the Council's Chairman discussed the proposal with the Membership Benefits Subcommittee of the Council on Membership. After evaluating the effect the proposal could have on membership recruitment efforts, the subcommittee agreed that the proposal should be supported, and this view was subsequently shared by the full Council on Membership.

The Council accepted the proposal to develop a dental school group enrollment arrangement for those schools having at least 50% membership among their students. It further accepted the proposal to amend the Income Protection Plan to permit coverage to be issued to dental school graduates who participated in the ADA Student Disability Insurance Plan regardless of the new dentists' membership status. It agreed that such dentists should be permitted to continue participating in the Income Protection Plan for a period of no more than five years following graduation in exchange for the payment of a $50 semiannual surcharge.

These proposals were approved by the Board of Trustees at its September 1995 meeting. The group enrollment arrangement is currently being introduced to eligible dental schools. It is the Council's hope that this initiative will be favorably received and make a significant contribution to the effort to recruit young dentists as ADA members.

Hospital Indemnity Insurance Plan: The Hospital Indemnity Insurance Plan is underwritten and administered by the Great-West Life & Annuity Insurance Company. It offers coverage that is intended to supplement major medical insurance policies and provides insured members with a benefit of up to $300 for each day they or one of their insured dependents is confined in a hospital. This protection offsets the considerable out-of-pocket expenses that can result from deductibles and other co-insurance features of many medical insurance policies.

As of December 31, 1995, there were 8,020 members insured under the Hospital Indemnity Plan. In addition, 3,764 participants were insuring their spouses and 1,647 were insuring their children. The number of children insured totaled 3,564. In 1995, $1,254,575 in benefits was paid by the Hospital Indemnity Plan on behalf of participants whose claims were reported during the year. As a result of the favorable financial experience of the Hospital Indemnity Insurance Plan, the Council approved a 40% credit for participants under 65 years of age to reduce the premiums payable on March 15, 1996 and September 15, 1996.

Office Overhead Expense Insurance Plan: The Office Overhead Expense Insurance Plan is underwritten and administered by the Great-West Life & Annuity Insurance Company. It provides the disabled dentist with reimbursement of specific expenses incurred in maintaining the dental office until a return to work is possible. This complements disability insurance, which is intended to replace net income. The Council believes that the ADA-sponsored Program's advantages include not only a very competitive array of benefits but also rates that are among the lowest in the marketplace.

Monthly benefits of up to $15,000 are offered with either a 15- or 30-day elimination period. Payments commence retroactively with the first day of disability once the waiting period has been satisfied and can continue until 24 times the maximum monthly benefit has been paid. The Plan's standard features also include Waiver of Premium, Partial Disability and Survivor's Income benefits, as well as a future insurability guarantee for participants who are under age 50.

During 1995, participation in the Office Overhead Expense Plan increased by approximately 6% to a total of 8,771 members at year-end. During the year, a total of $3,488,493 in benefits was paid to disabled participants. As a result of the favorable financial experience of the Office Overhead Expense Plan, participants are currently receiving a 20% premium credit.

ADA Members Retirement Program: The Association sponsors a tax-qualified retirement program as a benefit of membership. It offers competitively priced record-keeping, custodial and investment management services, as well as master plan documents that are preapproved by the Internal Revenue Service. Participants may elect the convenience of a package approach that consolidates these services with a single administrator, or they may use the Program only for investment purposes.

The Equitable Life Assurance Society of the United States provides the record-keeping and custodial services offered by the Retirement Program and maintains the tax-qualified status of its master plans. The company also serves as the investment manager for the Program's Money Market Guarantee Account, and its subsidiary, the Equitable Real Estate Investment Management Corporation, manages the Program's Real Estate Fund. Investment management services for the Program's equity investment options are provided by the following companies: Growth Equity Fund—Alliance Capital Management Corporation; ADA Foreign Fund—The Templeton Investment Counsel Corporation; Aggressive Equity Fund—Massachusetts Financial Services Company; Equity Index Fund—State Street Global Advisors; and Lifecycle Moderate and Lifecycle Conservative Funds—State Street Global Advisers. The Program's three- and five-year fixed income funds are variously invested with The Equitable Life Assurance Society, Metropolitan Life Insurance Company, John Hancock Life Insurance Company, Principal Mutual Life Insurance Company and New York Life Insurance Company.

Under the defined contribution master plan, dentists can select a profit-sharing or a pension arrangement, or a combination of both. This offers considerable flexibility in determining the annual contribution, which is computed as a percentage of each participant's annual compensation. A 401(k) arrangement can be added to the profit-sharing plan

and structured to permit the dentist to receive a greater percentage of the practice's total contribution.

One of the major advantages of the ADA Members Retirement Program is that the Master Plan is kept in compliance with changes in the tax laws at no additional charge. By contrast, dentists having individually designed plans typically incur substantial legal and accounting fees to make certain that their plans remain qualified. Similarly, for no additional charge, the Program can provide completed 5500 forms as well as assistance in submitting this information to the Internal Revenue Service. It will also prepare all tax reports and handle the required withholding when amounts are distributed to retiring participants.

Participating members can take advantage of consulting services on all aspects of the program as well as information on investment performance and counseling in selecting retirement benefit options. The Program offers toll-free telephone access to account balances and daily reporting of investment yields, as well as the ability to transfer funds among investment accounts by telephone on a 24-hour basis.

Upon retirement, participants are offered an array of choices for taking distributions. In addition to lump-sum and installment payments, a variety of annuities can be purchased. Annuities offered through the Program are underwritten by the Prudential, Metropolitan and Nationwide Life Insurance Companies.

As an alternative to the full-service arrangement, the dentist can elect to maintain an individually designed, IRS-approved plan while using the ADA Members Retirement Program only for investment purposes. The investment-only arrangement is designed for dentists who prefer to work with a particular attorney or pension consultant for plan design and administration, but wish to participate in the Program's investment accounts.

At the end of 1995, there were 8,680 plans in effect under the ADA Members Retirement Program, covering 20,072 dentists and their employees. At year-end, the Program had total assets approaching $1.03 billion.

Participants allocated 25.2% of their funds, or $260 million, to the Money Market Guarantee Account. This Account offers yields that are comparable to those of money market funds and the credited interest rate changes monthly. Participants are able to make contributions and withdrawals without restriction. The assets which stand behind the Program's obligations to participants in the Money Market Guarantee Account are held in separate account no. 43, established by The Equitable Life Assurance Society. Assets held in such separate accounts are insulated from the claims of an insurance company's policyholders and creditors.

Participants allocated 16.8% of their funds, or $172.6 million, to the Guaranteed Rate Accounts (GRAs), which provide a guarantee of both principal and interest. The credited rate of interest remains unchanged until maturity and is competitive with bank certificates of deposit of similar duration. New rates are set weekly. These fixed income products are designed to hold funds for the entire guarantee period, and premature withdrawals may be subject to certain restrictions or interest penalties.

Deposits in the GRAs are invested with insurance companies having very high credit ratings. This is accomplished through a process where qualified companies submit bids for deposits to be made within specified periods. At the end of 1995, the participants' assets were invested in the GRAs as follows: GRAs opened prior to February 6, 1991 are invested with The Equitable Life Assurance Society and at year-end 1995 were valued at $1 million; GRAs opened between February 6, 1991 and February 4, 1992 are invested with the Metropolitan Life Insurance Company and were valued at $18.4 million at year-end; GRAs issued between February 5, 1992 and February 2, 1993 are invested with the John Hancock Life Insurance Company and were valued at approximately $20.5 million at year-end; GRAs issued between February 2, 1993 and August 2, 1994 are invested with the Principal Mutual Life Insurance Company and were valued at $62.7 million at year-end; GRAs issued between August 3, 1994 and August 2, 1995 are invested with the Metropolitan Life Insurance Company and were valued at $60.5 million at year-end; and GRAs opened between August 2, 1995 and December 31, 1995 are invested with the New York Life Insurance Company and were valued at $9.4 million at year-end.

The participants deposited the remaining 58% of their assets in the Program's equity and real estate investment funds. The assets of each of these funds are held in separate accounts established by The Equitable Life Assurance Society. The returns offered by these funds are intended to reflect the performance of the markets in which they invest. The following summarizes the performance of these funds as represented by changes in the value of each investment unit held by Program participants. The reported changes in unit values assume that deposits were invested for the entire period and are not an indication of future performance. They do not reflect the subtraction of investment management fees, the ADA Members Retirement Program's expense charges, or direct expenses incurred by the funds.

Growth Equity Fund. The Growth Equity Fund holds 33.9% of the participants' assets, or approximately $349.6 million. It is invested in a portfolio managed by the Alliance Capital Management Corporation that primarily consists of stocks of intermediate- to large-size domestic companies. Its investment strategy is growth-oriented and its return is mostly derived from capital appreciation. For calendar year 1995, the Account's unit value increased by 32.5%, compared with a 30.8% increase in the Lipper Growth Mutual Funds Average and a 37.5% increase in the Standard & Poor's 500 Stock Index (S&P 500). Over the five-year period ending December 31, 1995, the Fund produced an average annual return of 19.6%, compared with an average annual increase of 16% in the Lipper Growth Mutual Funds Average and a 16.6% average annual increase in the S&P 500.

ADA Equity Index Fund. The ADA Equity Index Fund offers participants a method of investing in the broad domestic equity market and an alternative to the active management style of the Growth Equity Fund. The Fund holds units in the Seven Seas S&P 500 Index Fund managed by State Street Global Advisers, a subsidiary of the State Street Bank of Boston. Its returns are expected to mirror those of the S&P 500 Stock Index but will be slightly lower due to the deduction of investment management and program fees. Because the S&P 500 Index is not concentrated in any specific security or market sector, the Fund may be less volatile than narrowly focused equity funds or individual stock investments. It is also likely to be more broadly diversified and less volatile than most actively managed equity funds. Lastly, as the stocks of many of the nation's largest dividend-

paying corporations are included in the Fund's portfolio, investment return can be generated from both market growth and dividend reinvestment.

During 1995, the value of an investment unit in the Seven Seas S&P 500 Index Fund increased 37%, compared with a 37.5% increase in the S&P 500 Stock Index itself.

ADA Lifecycle Funds. The Lifecycle Fund Moderate and the Lifecycle Fund Conservative were introduced as new investment options on May 1, 1995. Designed to appeal to participants in the Retirement Program who are uncomfortable making their own investment decisions, the Lifecycle Funds offer a managed method of entering the equity markets. They also follow a passive investment approach in that the portfolios in which they invest seek to replicate the returns of the broad markets for various asset classes. In addition, the allocation of the Funds' assets among the investment markets is relatively fixed. Thus, there is minimal discretion allowed to portfolio managers in terms of securities selection, asset allocation or market timing.

The Lifecycle Funds were developed by the Council in response to Objective 7 of the ADA Strategic Plan, which calls for assisting members in financial planning for their retirements. The Council has noted that, in the aggregate, participants in the ADA Members Retirement Program tend to hold too much money in conservative fixed income investments which provide relatively low returns over the long term. It is believed that this results from a discomfort in making investment decisions as well as the short-term volatility of the equity markets. The Lifecycle Funds are designed to provide long-term yields that exceed those of fixed income investments with manageable amounts of market risk and short-term volatility.

Each of the Lifecycle Funds invests in five investment portfolios that are managed by State Street Global Advisers. These portfolios hold securities that replicate the performance of the broad market for a particular class of assets. These asset classes and the markets the portfolios seek to replicate are as follows: stocks of large-capitalization domestic corporations as represented by the S&P 500 Stock Index; stocks of small-capitalization domestic corporations as represented by the Russell 2000 Stock Index; stocks of foreign corporations as represented by the Morgan Stanley Europe, Australia and Far East Stock Index (EAFE); investment grade domestic government and corporate bonds as represented by the Lehman Brothers Government/Corporate Bond Index (LBGC); and short-term money market instruments as represented by yields on 90-day Treasury Bills.

Each Lifecycle Fund is rebalanced monthly to maintain the allocation of its assets among the five investment portfolios in the following percentages:

Index Fund	Conservative Fund	Moderate Fund
Russell 2000	3% to 7%	8% to 12%
EAFE	8% to 12%	13% to 17%
S&P 500	13% to 17%	33% to 37%
LBGC	48% to 52%	28% to 32%
90-day Treasuries	18% to 22%	8% to 12%

As of December 31, 1995, the Lifecycle Fund Moderate held 7.4% of the participants' assets, or $76.2 million. Of this amount, over $66.7 million represents the proceeds of the sale of the assets of the ADA Balanced Fund which, as discussed below, were transferred to the Lifecycle Fund Moderate on December 8, 1995. During the period from May 1, 1995 through December 31, 1995, the Lifecycle Fund Moderate produced a return of 11.3%.

As of December 31, 1995, the Lifecycle Fund Conservative held 0.3% of the participants' assets, or $3 million. During the period from May 1, 1995 through December 31, 1995, the Fund produced a return of 7.3%.

ADA Real Estate Fund. Approximately $4 million, or 0.4% of the participants' assets, is held in the ADA Real Estate Fund. It invests at least 90% of its assets in shares of the Prime Property Fund managed by the Equitable Real Estate Investment Management Corporation. The remaining assets are held in a money market fund. The Prime Property Fund is a portfolio of high-quality commercial real estate, with 179 properties having a value of approximately $2.9 billion. For the 1995 calendar year, the ADA Real Estate Fund's unit value increased by 0.2%, compared with an 8.9% increase in the National Council of Real Estate Investment Fiduciaries (NECREIF) Index. Although the properties owned by the Prime Property Fund generated income of 8.6%, this was offset by depreciation in their value of 9%, primarily as a result of falling values in the regional shopping malls which comprise 60% of the Fund's holdings. For the five-year period ending in 1995, the Real Estate Fund produced an average annual return of -0.4%, compared with an average annual return of 1.0% for the NECREIF index.

ADA Foreign Fund. Approximately 6.6% of the participants' assets, or $68.2 million, were invested in the ADA Foreign Fund. At any time, at least 95% of the assets of the ADA Foreign Fund are invested in shares of the Foreign Fund managed by The Templeton Investment Counsel Corporation. The remaining assets are held in a money market fund. For the 1995 calendar year, the ADA Foreign Fund's unit value increased by 10.9%, compared with an 11.6% increase in the Morgan Stanley Europe, Australia and Far East Stock Index (EAFE). For the five-year period ending in 1995, the Templeton Foreign Fund produced an average annual return of 12.6%, compared with a 9.7% average annual increase in the EAFE Index.

At its March 30, 1996 meeting, the Council approved a proposal to eliminate the ADA Foreign Fund's cash position effective May 1, 1996. On that date, all assets held in money market instruments were reinvested in additional shares of the Templeton Foreign Fund.

Termination of the ADA Balanced Fund. As Trustees of the ADA Members Retirement Program, the Council determined that the Balanced Fund should be discontinued as an investment option. It was the Council's judgment that the Balanced Fund was made redundant by the new Lifecycle Funds. For individuals favoring an asset allocation approach to investing, the Lifecycle Funds offer greater diversification and a passive rather than active management approach. It was also the Council's judgment that the recent performance of the Balanced Fund had not been favorable and that it was no longer meeting the objectives set forth in the Council's Investment Policy. For the one-year period ending November 30, 1995, the Balanced Fund's unit value increased by 21.1%, compared with a 27.6% increase in a 50/50

composite of the S&P 500 Stock and the Lehman Brothers Government/Corporate Bond indices. Over the five-year period ending November 30, 1995, the Fund produced an average annual return of 12.6%, compared with an average annual increase of 13.5% in the composite index. For these reasons, the Council directed that the Fund be terminated and that all of its assets be reinvested in the Lifecycle Fund Moderate, which has similar investment objectives.

The ADA Balanced Fund's assets were liquidated through an orderly sale of its securities in the regular markets. The liquidation was conducted by the Fund's portfolio manager, the Alliance Capital Management Corporation, over the nine-day period from November 27 through December 5, 1995. The proceeds from the sale of the Fund's assets were reinvested in the Lifecycle Fund Moderate on December 8, 1995. Participants in the Balanced Fund were sent advance notice of its pending termination in October and again in November 1995. Following the termination of the Fund, they were sent statements confirming the reinvestment of their Balanced Fund holdings in the Lifecycle Fund Moderate. The Council is pleased to report that no participants expressed concern regarding this change in the Retirement Program's investment options.

Change in Investment Vehicle for ADA Aggressive Equity Fund. At its March 1995 meeting, the Council directed that its investment advisers, the Mercer Investment Consulting Corporation, undertake a study of funds having a growth-oriented strategy to investing in stocks of small- to intermediate-sized domestic corporations. The purpose was to identify a replacement for the fund directed by the Alliance Capital Management Corporation which was the investment vehicle for the ADA Aggressive Equity Fund. This action was based upon a concern about the future ability of Alliance to meet the performance standards set forth in the Council's Investment Policy for the Aggressive Equity Fund. While the Fund's long-term results had been favorable, they were largely attributable to portfolio managers no longer with Alliance. The Council also expressed concern that Alliance's investment strategy had resulted in a portfolio that had considerable similarity to that of the Growth Equity Fund. While overlapping investment themes are not necessarily undesirable, they do limit the ability of the Retirement Program's participants to diversify investment risk and cause the performance of the funds to demonstrate a high degree of correlation.

A study of replacement investment managers was begun immediately following the March 1995 meeting of the Council. Initially, 13 investment funds were identified that had investment objectives consistent with the Council's Investment Policy and which had demonstrated acceptable levels of performance. Of these candidates, nine were eventually eliminated for reasons that included recent changes in portfolio management teams, unwillingness to work with the ADA Program or refusal to waive redemption fees and/or front-end loads. On-site evaluations were then conducted of the investment and administrative offices of each of the four funds identified as finalists, and meetings were held with their portfolio managers. These evaluations were conducted by the Council's investment consultant and its Director. Also attending were representatives of the Equitable Life Assurance Society, who evaluated each fund's ability to comply with the administrative requirements of the ADA Program. As a result of these interviews, it was concluded that the final selection could be based solely upon investment management issues as all of the candidates were deemed able to meet the basic requirements of the Program's systems.

Based upon the advice of its investment consultants, the Council approved the selection of the Massachusetts Financial Services Corporation's (MFS) Emerging Growth Fund to serve as the investment vehicle for the ADA Aggressive Equity Fund. This judgment was based upon the stability and strength of its portfolio management team, the quality of resources available to the investment managers and the clarity of the investment strategy. In terms of performance, the MFS Emerging Growth Fund also had the highest average annual returns for the five-year period ending June 30, 1995 of all the fund candidates considered. In addition, the MFS Emerging Growth Fund's existing asset base of approximately $2.2 billion would allow it to absorb the approximate $68 million of ADA Aggressive Equity Fund assets without affecting overall performance.

The Council noted that the MFS Emerging Growth Fund's investment management fee, as well as those of the other candidates, is higher than the fees charged by Alliance Capital, which are very low by industry standards. Specifically, the MFS Fund's fees for investment management are 1.33%, compared with Alliance's 0.35% charge. However, a portion of the MFS charge would be used to offset a 0.15% record-keeping charge that is applicable to the ADA Aggressive Equity Fund. This would be made possible by MFS' agreement to refund to the ADA Program its 12b-1 fee, which is equal to 0.25%. The MFS Fund would also waive its initial sales charge (front-end load) for participants in the ADA Program.

The Council judged that, although the participants will pay higher investment management fees than they presently pay, they will be provided with access to an investment fund that should provide a greater rate of return. Had the participants been invested in the MFS Fund over the past five years, their net average yield even after deduction of fees would have been higher than under the Alliance Fund.

Before accepting the MFS Emerging Growth Fund, the Council interviewed its portfolio manager, Mr. John Ballen. This interview took place at the Council's August 1995 meeting. Mr. Ballen provided an overview of his investment strategy. He explained that the Fund invests primarily in stocks of small- and medium-sized companies that are early in their life cycle but which have the potential to become major enterprises. This is accomplished by identifying companies with revenue and earnings growth of at least 20% per year that have the potential to become major players in emerging industries. He noted that fundamental analysis is the cornerstone of MFS' investment management and that he has a research staff of 20 industry analysts. In general, the Fund seeks to have maximum exposure of 25% of its assets in a single industry and no more than 5% in a single company. As of June 30, 1995, the Fund held stocks of 389 companies. However, the stocks of 40 companies represent approximately 70% of the portfolio. Companies that are candidates for purchase are those having an initial market capitalization ranging from $100 to $700 million. Of companies already included in the portfolio, the median capitalization is $228 million and the weighted average is $3 billion. The Fund's weighted price/earnings ratio is 17.1% and its Beta is 1.24 (i.e., the Fund is expected to outperform the market as a

whole by 24% in rising markets and underperform by 24% in down markets).

Based upon its discussions with Mr. Ballen and the recommendations of its investment consultant, the Council approved the use of the MFS Emerging Growth Fund as the investment vehicle for the ADA Aggressive Equity Fund effective December 1, 1995. The participants in the Aggressive Equity Fund were notified of the Council's action in October and November 1995 and were sent information about the MFS Emerging Growth Fund, including a prospectus. The Council is pleased to report that there were no expressions of concern among participants in the Retirement Program over the selection of the MFS Emerging Growth Fund.

At the end of 1995, the ADA Aggressive Equity Fund held 7.5% of the participants' assets, or $76.8 million. Given the change in its investment vehicle, its returns reflect the performance of two different managers. From January 1, 1995 through November 30, 1995, when the Fund was managed by the Alliance Capital, its unit value increased by 30.3%, compared with a 32.4% increase in the Lipper Small Company Growth Funds Average. During the month of December, when the Fund was invested in the MFS Emerging Growth Fund, its unit value declined by 0.4%. For the full 1995 calendar year, the MFS Emerging Growth Fund had a 41.2% increase in value.

ADA-Endorsed Individual Retirement Account: The Association endorses an Individual Retirement Account (IRA) Program as a benefit of membership that is available to members, their spouses and employees. The Program is administered by The Equitable Life Assurance Society.

The participants' contributions to the IRA Program may be allocated to one- or three-year guaranteed rate accounts which are invested with The Equitable Life Assurance Society, or to the Hudson River Trust, a mutual fund with various investment portfolios managed by the Alliance Capital Management Corporation. The investment portfolios held in the Hudson River Trust include Money Market, Common Stock, Aggressive Stock, Balanced, Government Securities, Global and High Yield Funds.

As of December 31, 1995, there were 2,009 participants in the ADA-endorsed IRA. The total value of their investments was in excess of $62.5 million. These assets were invested as follows: One- and Three-year Guaranteed Rate Accounts, 10.2%; Money Market Fund, 14.8%; Common Stock Fund, 40.7%; Government Securities Fund, 2.7%; Balanced Fund, 17%; High Yield Fund, 1.3%; Aggressive Stock Fund, 5.9%; Global Fund, 4.3%; Growth Investors, 1.1%; Conservative Investors, 0.8%; and Growth and Income, 1.3%.

The percentage change in unit values for the investment funds for calendar year 1995 were as follows: Money Market Fund, 5.7%; Common Stock Fund, 32.5%; Government Securities Fund, 13.3%; Balanced Fund, 19.8%; Aggressive Stock Fund, 31.6%; Global Fund, 18.8%; High Yield Fund, 19.9%; Growth Investors, 26.4%; Conservative Investors, 20.4%; and Growth and Income, 24.1%.

The reported changes in the unit values for the aforementioned funds assume that deposits were invested for the entire period and are not an indication of future performance.

Practice Security Program: The Practice Security Program was introduced as a benefit of membership in 1989. It offers the dentist professional liability insurance, as well as an optional package of property loss, business liability and practice interruption coverages designed to meet the needs of dental offices. The Program is offered under the auspices of the ADA Risk Purchasing Group, Inc., and is administered and marketed by Kirke-Van Orsdel Specialty, Inc. It is underwritten by the Reliance National Insurance Company.

As of December 31, 1995, there were 1,057 members participating in the Practice Security Program, compared with 1,032 at the end of 1994. The Program's optional dental office package was purchased by 164 participants.

Association Involvement in the Professional Liability Insurance Marketplace: It was reported to the 1995 House of Delegates that the Board of Trustees accepted a recommendation of the Council that Association sponsorship of the Practice Security Program be discontinued (*Trans.*1995:544). In response, the House adopted Resolution 78H-1995 (*Trans.*1995:603), which directed that prior to the sponsorship or endorsement of any national professional liability insurance program the Board shall obtain the House's approval.

The withdrawal of the Association's sponsorship of the Practice Security Program was based upon the recommendation of the Council on Insurance. It was the Council's judgment that there is no longer a need for an ADA-sponsored program in order to assure the membership a stable source of coverage at reasonable rates. Instead, the Council recommended that the Association should serve as a central source of information for the membership on the broad array of options for their professional liability insurance, as well as on emerging trends in claims and general market conditions.

At its first meeting following the 1995 House of Delegates, the Council took immediate steps to establish alternative methods by which the Association can exert influence and involvement in the professional liability insurance marketplace as directed by Resolution 94H-1986 (*Trans.*1986:524). The Council agreed that its future activities in the professional liability insurance arena will have three major components:

1. to accumulate and disseminate information on the incidence, cost and factors giving rise to dental malpractice allegations and incidents;
2. to disseminate information that will assist dentists in selecting professional liability insurance policies that best meet their needs; and
3. to act as the primary point of contact between the professional liability insurance industry and organized dentistry for the purposes of improving the quality of care and reducing the costs of coverage.

The Council believes that the availability of professional liability insurance at reasonable cost can best be assured through a competitive marketplace. Competition prevents insurers from sustaining premiums at levels unjustified by claim experience. It also forces them to offer products that are as liberal as possible with respect to the terms and conditions of coverage. To do otherwise results in a loss of market share. However, the efficiency with which the market penalizes noncompetitive insurers is dependent upon the

degree to which dentists are discerning consumers of insurance products.

The Council believes that the Association can provide a valuable service to member dentists and facilitate competition in the insurance marketplace by helping members understand their policies and compare them with available alternatives. When dentists are aware of all of their options and know how to change policies without risking an interruption in coverage, then insurers cannot make unfair pricing or underwriting decisions without risking a large loss of business. To this end, the Council will develop and make available a comprehensive listing of all sources of coverage available to the membership in each state. Dentists calling the Council's office for information about coverage alternatives will be sent the list for the state in which they practice. This list will also be sent to each of the constituent dental societies.

As in the past, the Council will continue to monitor overall conditions in the professional liability insurance market and alert dentistry's leadership to problems that could impact the cost of coverage. These problems could result from emerging trends in litigation, changes in practice patterns or government regulation. In addition, the Council will seek to gather information about the factors that give rise to dental malpractice allegations as well as trends in their incidence and severity. Currently, the Association has no source of such information. Data on the number, severity and causes of professional liability claims is only available in the records of professional liability insurance companies or the National Practitioners Data Bank. Little of this information is publicly available. For this reason, the Council will seek to establish a cooperative relationship for the purpose of gathering and sharing information with all of the major underwriters of dental professional liability insurance policies. If this can be achieved, the Association will have a source of information on the claims experience of a very broad segment of the profession, not just those dentists insured by a particular company as in the past. This information will be used to help the Association develop professional liability risk management and continuing education programs, as well as to lobby for appropriate reforms in the regulation of the insurance marketplace and in tort laws.

The Council has established contact with a number of insurance companies that insure a significant number of dentists. These companies have indicated a willingness to share loss data if the goal is to encourage loss prevention or improvements in the legal and regulatory environment. However, before the information can be publicly disclosed, it will have to be collected from a sufficient number of insurance companies to assure that it is representative of the membership both geographically and by special area of practice. In addition, aggregation of the information will be a precondition for public disclosure in order to meet the confidentiality requirements of the insurance companies.

At its March 1996 meeting, the Council had the first of its discussions with a professional liability insurer. Representatives of the CNA Insurance Companies (CNA) shared extensive data on its dental professional liability claim experience. In addition, there was extensive discussion of areas of dental practice that are most frequently involved in claims, as well as the professional liability ramifications of managed care, dental office waterline contamination, latex allergies, patient premedication and other topical issues. As a result of this discussion, several immediate opportunities were identified for the Association and CNA to cooperate in ways which can advance the profession's interests.

The Council has established a dialogue with several additional commercial insurers and doctor-owned companies. They include the Cincinnati Insurance Company, The Dentists Insurance Company of California, the Eastern Dentists Insurance Company, the Medical Protective Insurance Company, the Physicians Insurance Company of Michigan and the Safeco Insurance Company. Contact has also been made with the Physicians Insurance Association of America (PIAA), an organization whose members include companies that insure dentists in many states and which are endorsed by seven constituent dental societies. As part of its annual meeting, the PIAA will hold a workshop on dentist claim trends which will be attended by a member of the Council.

The Council believes that by serving as a conduit for the exchange of information between the insurance industry and organized dentistry, it can identify meaningful opportunities for the Association to assist the membership in reducing the number and severity of malpractice allegations. This will contribute to the quality of dental care and help control the cost of professional liability insurance. The Council believes that these activities represent the most beneficial way for the Association to advance the profession's interests in the insurance marketplace.

Rescission of Policy Regarding National Administrators of ADA Insurance Programs Serving As State Administrators: Resolution 15H-1995 (*Trans.*1995:659) directed Association councils and commissions to review appropriate policies to determine whether they should be modified or rescinded. The Council believes that the following policy established by Resolution 72H-1986 (*Trans.*1986:523) is moot and should be rescinded:

> **Resolved,** that the ADA House of Delegates establish a policy that when a national administrator of any ADA-sponsored insurance program also serves as a state administrator for that insurance program, it shall be governed and abide by the same conditions, contracts and rules as all other state administrators of that insurance program.

This policy was adopted in response to a disagreement relating to the administrative arrangements of the Professional Protector Plan (PPP) which the Association ceased endorsing in 1986. The PPP was administered nationally by Poe & Associates, but in each state, a local administrator could be designated by the constituent dental society if it agreed to co-endorse the Program. The only exception was Florida, where Poe & Associates was located and, as a result, also served as the PPP's state administrator.

The PPP was the only insurance program endorsed by the Association that used both state and national administrators and no new such programs are envisioned. For this reason, the Council believes that the policy established by Resolution 72H-1986 is moot and should be rescinded.

25. Resolved, that Resolution 72H-1986 (*Trans.*1986:523), Policy Regarding National Administrators of ADA Insurance Programs as State Administrators, be rescinded.

Acknowledgments: The Council wishes to express its appreciation for the contributions of Dr. Robert Kent, Dr. Skip Magruder and Dr. John Williams, who have completed their service as members of the Council on Insurance. The success of the Association-sponsored insurance and retirement programs is due in no small part to the sound judgment and decisions of these member dentists.

Support for the ADA Health Foundation: The Council wishes to acknowledge with gratitude the very generous support given the ADA Health Foundation by the Great-West Life & Annuity Insurance Company and The Equitable Life Assurance Society of the United States.

Support for the American Dental Association SUCCESS 94-95: The Council also wishes to express its appreciation to The Equitable Life Assurance Society of the United States and the Great-West Life & Annuity Insurance Company for their support of the Association's SUCCESS Program, conducted for the benefit of junior and senior dental students.

Summary of Resolutions

25. Resolved, that Resolution 72H-1986 (*Trans.*1986:523), Policy Regarding National Administrators of ADA Insurance Programs Serving as State Administrators, be rescinded.

Divisions of Government Affairs and Legal Affairs

Council on Ethics, Bylaws and Judicial Affairs

Council on Governmental Affairs and Federal Dental Services

Notes

Council on Ethics, Bylaws and Judicial Affairs

Buford, Skip D., Louisiana, 1996, chairman
Meador, Robert C., Texas, 1996, vice chairman
Barwick, Karen D., North Carolina, 1996, *ex officio**
Bauer, Frederick J., Wisconsin, 1996
Bluitt-Foster, Juliann S., Illinois, 1999
Cutler, A. Riley, Idaho, 1999
Gallagher, William L., California, 1998
Gillespie, M. Joan, Virginia, 1998
Gross, Ronald B., Pennsylvania, 1999
Hoffmann, Cordelia E., Wyoming, 1997
Kaufman, Gerry L., Indiana, 1997
McDonnell, Robert E., Minnesota, 1996
Merritt, Grant W., Missouri, 1999
Mitchell, G. Lewis, Jr., Alabama, 1998
Noonan, Howard L., New York, 1997
Rosen, Robert, Delaware, 1997
Singer, Lawrence J., Connecticut, 1998
Todd, Kathleen, director
Wils, Wendy, manager

Meetings: The Council met on January 6-8, 1996 at the Headquarters Building in Chicago. The second Council meeting of 1996 is scheduled for June 1-3 in Chicago. Dr. Robert M. Anderton, Fifteenth District trustee, served as liaison to the Council for the Board of Trustees. Mr. Brad Wall attended the January Council meeting as liaison for the American Student Dental Association.

Vice Chairman: Dr. Robert C. Meador was elected vice chairman of the Council to serve until the close of the 1996 annual session.

Appreciation: The 1996 annual session will mark the retirement of Dr. Skip D. Buford, who served as Council chairman in 1996. Also retiring from the Council are Dr. Robert E. McDonnell, Dr. Robert C. Meador and Dr. Frederick J. Bauer. The Council expresses its gratitude to these individuals for their leadership, contributions and dedication during their tenure.

The Strategic Plan of the American Dental Association: The Council continues to support the Association's Strategic Plan with the following activities.

- The Council has a *Bylaws* duty to interpret and recommend changes to the *ADA Principles of Ethics and Code of Professional Conduct* (*Code*). The *Code* sets the ethical standards on which dentistry's professional image is based. The Council also issues new advisory opinions to keep the *Code* current and meaningful to practitioners. These actions support the Association's mission to enhance the integrity and ethics of the profession.
- The Council serves as the body that hears appeals from decisions of constituent and component dental societies. The Council's role as an appellate body fosters effective self-regulation of the profession and lessens the need for government regulation, in support of Objective 1, Legislative and Regulatory Advocacy.
- The Council's sponsorship of the ethics component of the SUCCESS program for dental students has a positive effect on Objective 3, Membership Recruitment and Retention, by fostering professional identification among dental students with organized dentistry. The SUCCESS program also serves to promote Objective 5, Dental School Education and Board Examinations by improving the quality of dental education.
- The Council serves as the sole judge of the Golden Apple Award for Outstanding Achievement in the Promotion of Dental Ethics. Recognition of constituent and component dental societies' activities promotes their awareness of the *Code* and serves to strengthen their relationship with the Association and foster greater involvement. This supports Objective 3, Membership Recruitment and Retention.
- Council members attend and present at conferences in the field of ethics to enable the Council to strengthen relationships with associated organizations in the field of ethics and to benefit from the thinking of leading ethicists on critical ethical issues. Such activities support Objectives 6, Professional Image, and 10, Associated Organizations. Productive dialogue with leading thinkers in the field of ethics directly affects the Association's ability to remain a credible source of information and advice on critical issues with strong ethical overtones such as AIDS, amalgam and managed care.
- The Council supervises publication of the *Bylaws* and the *Code* and their distribution to ADA agencies and the constituent and component societies. Access to current copies of these documents enables these entities to govern themselves in support of Objective 9, Governance.

* Standing Committee on the New Dentist member without the power to vote.

Judicial Procedures

Appeals from Disciplinary Actions: One of the Council's *Bylaws* duties is to sit as the ultimate appellate body in review of decisions by the constituent and component societies in disciplinary matters. Since its last report, the Council has decided two appeals. Edited copies of the Council's opinions and decisions in these two cases are provided below.

Appeal of Dr. [ ]:** Dr. [ ] (Appellant) appealed to the Council from the penalty of expulsion imposed by his constituent society (Respondent). The Respondent received a complaint from a patient that the Appellant was frightening patients into having amalgam restorations removed by misrepresenting their health hazard. Subsequently, the Respondent obtained a tape recording of a radio talk show featuring the Appellant on the subject of dental amalgam.

Following an investigation, the Respondent brought charges against the Appellant for violating Section 1-K of the *ADA Principles of Ethics and Code of Professional Conduct* (*ADA Code*) and Sections 2 and 10 of the Respondent's code of ethics. A hearing was held at which the Appellant had the opportunity to present testimony and examine the witnesses against him. Based on the evidence presented, the Respondent found the Appellant guilty of violating Sections 1-K of the *ADA Code* and Section 10 of the Respondent's code and imposed the penalty of expulsion from the dental society. The penalty was stayed pending successful completion by the Appellant of three years' probation. During the probationary period, the Appellant would be required to submit all of his professional advertising to his component society for review and approval. The Appellant brought this appeal to the Council pursuant to the ADA *Bylaws*. Both the Appellant and the Respondent filed written briefs and appeared before the Council in the person of their attorneys to present oral argument.

Section 1-K of the *ADA Code* states:

> 1-K. REPRESENTATION OF CARE. Dentists shall not represent the care being rendered to their patients in a false or misleading manner.

Section 10 of the Respondent's code of ethics provides:

> Section 10. ADVERTISING. Although any dentist may advertise, no dentist shall advertise or solicit patients in any form of communication that is false or misleading in any material respect. In order to properly serve the public, dentists should represent themselves in a manner that contributes to the esteem of the public. Dentists should not misrepresent their training or competence in any way that would be false or misleading in any material respect.

The Appellant raised a number of substantive and procedural issues on appeal, which the Council considered in turn.

1. Sufficiency of the Evidence. The Appellant argued that there was insufficient evidence to find him guilty as charged. The evidentiary standards in a disciplinary proceeding are not as strict as in a court of law. In reviewing the decision of a constituent or component society, the Council typically asks whether there was sufficient reliable evidence bearing on the specific charge that a reasonable hearing panel could have reached the same conclusion. The Council will not second-guess a hearing panel about the reliability of evidence unless it is clear that a mistake has been made.

The Council found ample evidence in the record to support the Respondent's decision that the Appellant violated Section 10 of the constituent's code of ethics. As a preliminary matter, the Council agreed with the Respondent's conclusion that the radio talk show was designed to solicit patients for the Appellant's practice and, thus, was governed by Section 10 on advertising. The hosts of the talk show were identified as counselors at a medical/dental center with which the Appellant was associated. Throughout the show, listeners were invited to call the center for more information. A listener who sought a referral to a practitioner in another community was encouraged to visit the medical/dental center instead.

The Respondent had ample reliable evidence from the audiotape and transcript of the radio talk show to conclude that statements made by the Appellant during the program were false or misleading in a material respect. A statement may be misleading if it omits a material fact needed to make the statement considered as a whole not materially misleading or if it is intended or likely to create an unjustified expectation about the results a dentist can achieve. The Appellant's statements were misleading on both counts when viewed in the context of the radio program as a whole. The context of the program was provided by one of the hosts, who stated in his introduction (all quotes are from the transcript of the radio talk show introduced into evidence at the disciplinary hearing):

> The most common kind of dental fillings are called amalgam fillings or silver fillings. In reality, they are made up of more than 50% mercury, an extremely toxic and poisonous chemical. As people in this country discover more about how much mercury and other metals in the body can ruin their health, more and more people are choosing to have the mercury fillings removed and replaced with healthy, non-toxic materials. When patients have their silver fillings, that is their mercury fillings, replaced with healthy materials, some of the most common ailments, like depression, fatigue, allergy, headaches, memory loss and so forth, can improve dramatically. To help us understand how mercury fillings can adversely affect our health and to give us some of the latest research on this issue, our special guest today is [the Appellant]. [The Appellant] is our director at [the dental center].

The Appellant then discussed the results of a survey on the health effects of the removal of dental amalgam on patients. The survey consisted of the statements of approximately 762 patients who reported improvement in their health after

** The names of the parties have been purposefully omitted.

removal of their amalgam fillings. These were apparently self-reports compiled by "non-toxic" dentists, including the Appellant. The Appellant made the following statements about the survey results during the radio program:

- "About a quarter of the people had significant improvements in their depression after taking out mercury fillings. They had 100% of the symptoms either got better or cured by taking out the mercury fillings."
- "We had almost half, 43% of the people had improvements in their fatigue and wanted to report on it and of those people, 95% got better or cured."
- "A lot of the kids you've seen allergies come up more and more in kids than other adults and on taking out the mercury fillings you almost get 90% of the people getting improvement in their health or they're completely cured."
- "Well, again this is about a third of the people are having headaches, migraines, chronic headaches that come on often and they got 95% of the people either got better or cured with us. That's a significant improvement in any of the headache symptoms."
- "Six percent of the people brought up this multiple sclerosis. There's probably more people that didn't report it on the report, but about 79% or 80% of the people got improvement in their symptoms or, if you can call it completely cured, they had remission of most of their symptoms."
- "Eleven people in the study, it's not a very big number, but 11 people in the study had tinnitus and ear infections and ear problems and 100% of those people got better."

Commenting on people with short-term memory loss, the Appellant stated that about 94% of the people got better or were completely cured from taking out their mercury fillings.

At his disciplinary hearing, the Appellant claimed that he was merely reporting second-hand the results of a survey done by someone else. He denied any personal belief in the ability to cure or alleviate chronic health conditions by removing dental amalgam. However, these assertions were belied by the Appellant's own statements during the radio broadcast. At one point, a host asked the Appellant to comment on depression. The Appellant answered:

> Well, what we are trying to do in this clinic and in the medical center and the dental center is to get to the root causes. And one of the root causes for depression is the way that mercury changes the chemistry in the brain. And you get into a lot of long terms for the chemicals that are in the brain, but basically the mercury vapor gets into the bloodstream and goes up to the brain and it changes the endorphines [sic] or some of the other neurotransmitters that are in the brain and inhibits the chemistry of the brain and changes the balance.

Later, the host commented, "Now you've seen some improvement on the mercury. It's a slower improvement most of the time. Why don't we hit on what do you see as the biggest life changers when you do dental work as far as seeing the health change." The Appellant replied:

> A couple of other areas that you're bringing up there are things like taking mercury from underneath crowns or a root canal teeth, you see significant almost immediate improvements in some of these people. They just get right up out of the chair and they see their thought processes clear up and kind of like their brain opens up and they have clear thinking now.

These statements cross the line between merely reporting the results of someone else's survey and representing that the results are accurate and representative of what a listener might expect from treatment. Certain statements quoted above make clear that the Appellant was the source of some of the reports contained in the survey. The Council agreed with the Respondent that such statements were likely to mislead the listener into believing that removal of dental amalgam by the Appellant had the capacity to cure or alleviate certain chronic health conditions.

Claims that chronic health conditions can be cured by the removal of dental amalgam are not supported by accepted scientific evidence. The authorities agree that there is no health reason to remove serviceable dental amalgam from the nonallergic patient. Cases of allergic reaction to dental amalgam are extremely rare. No more than 100 cases have been documented in the dental literature. The Appellant himself introduced into evidence at his disciplinary hearing the most comprehensive study on the safety of dental amalgam conducted to date: the Final Report of the Subcommittee on Risk Management of the Committee to Coordinate Environmental Health (CCHERP) of the Public Health Service (January 1993). The CCHERP report undermines much of the information given by the Appellant to the radio audience. After an exhaustive review of the scientific literature, the report concluded:

> [T]here is no evidence at the present that the health of people with amalgam is compromised in any way. Likewise, there is no evidence that removing amalgam has a beneficial effect on health, despite anecdotal reports of "improvement" after amalgam removal in patients with certain chronic illnesses.

These findings are consistent with previous studies by the U.S. Food and Drug Administration and National Institutes of Health.

The Appellant made no mention of the CCHERP report during the radio program or of the limited scientific value of the type of anecdotal stories reported in the survey. Nor did the Appellant disclose to listeners that documented cases of allergic reaction to dental amalgam are extremely rare or that removal of existing dental amalgam has risks of its own and may expose patients to additional mercury or damage the structure of healthy teeth. He also failed to mention that alternative dental restorative materials could have unknown toxicity problems of their own. The Council believed that disclosure of at least some of these facts was necessary to make the Appellant's other statements not materially misleading.

On the other hand, the Council found no evidence in the record to support the Respondent's decision that the Appellant violated Section 1-K of the *ADA Code*. Both Section 10 of the constituent's code of ethics and Section 1-K of the *ADA Code* prohibit representations that are false or misleading in a material respect. They differ in that Section 1-K concerns representations made by dentists to their patients, whereas Section 10 concerns representations made by dentists to the

general public. There was no evidence in the record concerning any representations made by the Appellant to his patients. The letter of complaint from one of the Appellant's patients was introduced at the disciplinary hearing only for the limited purpose of showing why the Respondent initiated an investigation into the Appellant's practices, not for the truth of the statements contained in the letter. Thus, the statements in the letter could not be considered in determining whether a violation of Section 1-K occurred. Proof that the Appellant made false or misleading representations about care rendered to his patients would have been necessary to establish a violation of Section 1-K.

2. State Law. The Appellant asserted on appeal that the procedure followed by the Respondent to find him guilty violated state law. The Council disagreed. The state's corporations code provides statutory authority for termination of membership in a nonprofit mutual benefit corporation like the Respondent. In addition, the state's courts have laid down certain common law procedural requirements for expulsion from membership. Arguably, these requirements do not apply to a voluntary membership association like the Respondent. However, accepting for the sake of argument that they did, the Council was satisfied that all applicable legal requirements were satisfied in this case, including compliance with the bylaws of the Association and the Respondent.

The Appellant received written notice of the charges against him. The charges specified the ethical provisions he was alleged to have violated and contained a description of the conduct alleged to constitute each violation. The Appellant was given a hearing at which he appeared represented by counsel. He had an opportunity to cross-examine the witness against him and to present evidence in his own defense. The Appellant was given an opportunity to question the members of the hearing panel concerning possible bias and interest. In short, the Appellant was given all the process required for a fair and reasonable hearing.

3. Excessive Penalty. The Appellant questioned the propriety of imposing the penalty of expulsion for the offense committed. Although the Council disagreed in part with the basis of the Respondent's decision, it agreed that the penalty imposed was not excessive. Expulsion was an appropriate penalty for the conduct involved in this case, and the Appellant made no argument in mitigation. Rather, the Appellant argued his innocence and the failure of the Respondent's evidence. That was certainly his right, but, as a result, there was nothing in the record that would warrant mitigation of the penalty of expulsion.

4. Constitutionality. Finally, the Appellant argued that the conditions established by the Respondent for probation (i.e., that the Appellant submit his professional advertising to review) amounted to an unconstitutional restriction on his right of free speech and an unreasonable restraint of trade. The Council noted that the Constitution applies to government agencies, not private entities such as the Respondent. Therefore, constitutional arguments were irrelevant to this proceeding. The purpose of the terms of probation imposed on the Appellant was to safeguard the public from false or misleading advertising. False or misleading advertising serves no public purpose and enjoys no protection under federal or state antitrust laws.

For these reasons, the Council unanimously upheld the decision of the Respondent that the Appellant violated Section 10 of the Respondent's code of ethics and merited the penalty of expulsion. The Council reversed the decision of the Respondent that the Appellant violated Section 1-K of the *ADA Code*.

Appeal of Dr. [ ]:** The Appellant is a retired member of his constituent and component dental societies who currently practices general dentistry. This appeal arose from the decision of the constituent and component (collectively, Respondents) denying the Appellant's request to change his membership status from retired to active member. Because of the tripartite membership requirement of the American Dental Association, this denial would have prevented the Appellant from continuing his membership in the Association and deprived him of insurance and other associated benefits. It would also have prevented membership in any other organizations that require Association membership.

The record in this case showed that following the surrender of the Appellant's license to practice dentistry in his state, he sought and was granted a change in his membership status from active to disabled member in 1989, and to retired member in 1991. The Appellant's license to practice dentistry was reinstated in 1993 and he applied later that year for a change in membership status to active member. In November 1993, the component denied his application, and in September 1994, the component disapproved the application for a second time. On January 18, 1995, the constituent informed the Appellant by letter that he could appeal the component's decision to the constituent. The Appellant responded on February 10, 1995 that he wished to appeal. On March 15, 1995, the constituent wrote denying the appeal and informing the Appellant of his right to appeal to this Council. In May 1995, the Council agreed to hear the appeal. Throughout this process, the Appellant proffered his check for payment of his dues but the constituent refused to accept his dues payments. By refusing to transfer the Appellant to active member status while claiming that he was no longer eligible for retired membership, the Respondents tried to make Appellant a nonmember against his wishes.

The Council appreciated the unusual circumstances that gave rise to this case, and understood the desire of the parties to protect their respective rights and interests. It seemed likely that when the Appellant was permitted to transfer to a retired member status, the Respondents acted out of concern not only for the Appellant but also his family, trying to find a way of permitting them to retain their insurance coverage. However, with the subsequent reinstatement of Appellant's dental license, it became necessary for him to transfer back to active membership in order to sustain his membership and keep his benefits. The component consulted various legal counsel and, supported by their opinions, decided to require the Appellant to comply with Article III, Section 3 of its bylaws. In compliance with this requirement, the Appellant filed an application at two different times and both were denied.

** The names of the parties have been purposefully omitted.

The Council agreed to consider the issue of whether the Respondents' denial of the Appellant's transfer of membership status complies with the ADA *Bylaws*. The procedure for appeals to this Council is outlined in Chapter XII of the ADA *Bylaws*. Chapter XII, Section 20.D provides that parties to the appeal have the right to file briefs in support of their position, or they have the right simply to rely on the record. Parties also have the right to appear at the appellate hearing, either in person or by an attorney, and present oral arguments to the Council. The Council conducted this hearing in Chicago at the Association Headquarters Building. In this case, the parties filed briefs and their legal counsel presented oral arguments at the hearing.

Prior to the hearing before the Council, the Appellant and the Respondents filed several motions. The Council denied the Respondents' motion to present testimony and granted the Appellant's request to strike an affidavit submitted by the Respondent since, as an appellate body, the Council does not take testimony or otherwise engage in fact-finding. The Council determined that it would rule on the Appellant's motions to strike portions of the record and the Respondents' brief as part of its decision following oral argument.

The provisions of Chapter XII, Section 20.D of the ADA *Bylaws* provide the general framework for proceedings in appeals to the Council on Ethics, Bylaws and Judicial Affairs. Within this general framework, the Council has a wide measure of discretion to grant or deny motions to strike. Consistent with appellate procedure in federal and state courts, it is the Council's view that motions to strike portions of the record or the opposing party's brief are not favored and should not be granted unless it is clear that the matters to be stricken could have no possible bearing on the subject matter of the case and would be clearly prejudicial to the party. Included would be libelous and scandalous matter wholly aside from the issues of the case; extraneous, irrelevant and improper charges made without justification trying to confuse the issue; or comment that is disrespectful to the Council itself or opposing legal counsel.

In this case, the Council believed that all of the information contained in the record and the Respondents' brief, with the exception of the affidavit, had a bearing on the subject matter of this case, was not prejudicial to the Appellant on this appeal, and was needed to understand how the instant case arose and why certain conclusions were reached in the way that they were by the component and constituent societies. Therefore, the Council denied both motions to strike.

The issues in this case were:

1. whether a member automatically becomes a nonmember at the time of requesting a change from one classification of membership to another;
2. whether a component dental society may require a retired member to apply anew for membership when requesting a change to active member status; and
3. whether denying a request for change of classification resulting in the member becoming a nonmember amounts to an expulsion which triggers the due process protections of Chapter XII of the ADA *Bylaws*.

It was the Council's opinion that a member does not become a nonmember simply by requesting a change in membership classification, and that a component society cannot treat a member as a nonmember and require him or her to reapply for active membership. The Council also believed that denying a member's rightful request for a change of membership classification that has the effect of revoking the individual's membership is, in fact, an expulsion.

The ADA *Bylaws* set forth the requirements a constituent or component society may impose on membership, and they prohibit constituent and component society bylaws, rules and regulations from conflicting with, or limiting, the ADA *Bylaws*. It was the Council's opinion that bylaws must be construed as a whole. The particular meaning attached to any word or phrase or to silence in the bylaws on a particular point is ascertained from the context, the nature of the subject matter treated and the purpose or intention of the House of Delegates that adopted the bylaws. Therefore, the entire bylaws must be read together because no part is superior to any other part. After a study of the entire bylaws, a particular portion may be determined as controlling. If that portion is clear and unambiguous, the only duty is to apply it.

ADA Bylaws. The two classifications of membership at issue in this case were active and retired member. Under the ADA *Bylaws*, to be an active member a dentist must be a member in good standing of the Association and licensed to practice dentistry in a state, the District of Columbia, the Commonwealth of Puerto Rico or a dependency of the United States. Also, the dentist must be a member in good standing of this Association's constituent and component societies, if they exist. (ADA *Bylaws*, Chapter I, Section 20.A.) An active member in good standing who is a retired member of a constituent society and no longer earning income from the performance of service as a member of the faculty of a dental school, as a dental administrator or consultant, or as a practitioner of any activity requiring a license to practice dentistry or dental hygiene, may be classified as a retired member of the Association. (ADA *Bylaws*, Chapter I, Section 20.G.) For each of these classifications of membership, the ADA *Bylaws* refer to the member being "in good standing." A member of the Association is considered to be in good standing when dues for the current year have been paid. (ADA *Bylaws*, Chapter I, Section 30.)

The limits of a constituent society's authority in regard to membership are set forth in Chapter II of the ADA *Bylaws*. Active, life and retired members in good standing enjoy all privileges of constituent society membership, except as otherwise provided by the ADA *Bylaws*. Constituent societies may establish bylaws, rules and regulations to govern their members provided those bylaws, rules and regulations do not conflict with or limit the ADA *Bylaws*. A constituent society may discipline any of its members (that is, active, retired, etc.) subject to the provisions in Chapter XII, Section 20 of the ADA *Bylaws*. (ADA *Bylaws*, Chapter II, Sections 30.C, 30.D, 40.C and 70.)

Similarly, the limits on the authority of a component society in regard to membership are set forth in Chapter III of the ADA *Bylaws*. Active, life and retired members in good standing shall have the opportunity of enjoying all privileges of component society membership, except as otherwise provided by the ADA *Bylaws*. That includes membership in whatever classification the member is eligible for and discipline subject to the protections afforded in Chapter XII, Section 20. The tripartite membership requirement provides that the component's active, life and retired members must be members in good standing of their constituent society and the

Association. The component also must maintain a constitution and bylaws that are not in conflict with nor limit the constitution and bylaws of the Association or its constituent society. The component society may discipline any of its members subject to the provisions of Chapter XII, Section 20 of the ADA *Bylaws*. (ADA *Bylaws*, Chapter III, Sections 10, 20.B, 20.C and 30.)

Once a dentist is a member, that membership continues until one of four things happens:

1. the member fails to pay dues in a timely fashion;
2. the member resigns;
3. the member dies; or
4. the member is disciplined and expelled in accordance with Chapter XII of the ADA *Bylaws*.

Under Section 20 of Chapter XII, a member may be disciplined by the member's component or constituent society for:

- having been found guilty of a felony;
- having been found guilty of violating the dental practice act of the state; or
- violating the *Bylaws* or the *Principles of Ethics and Code of Professional Conduct* of the Association, or the code of ethics of the constituent or component society.

Before a disciplinary penalty may be invoked against a member, the member is entitled to written notice of the charges, including a specification of the bylaws or ethical provision alleged to have been violated; the opportunity for a hearing to present a defense; and a written decision specifying the charges, the facts substantiating the charges, the verdict and the penalty to be imposed or the conditions of probation, if any.

Constituent Bylaws. The bylaws of the constituent society define an active member as follows.

> All dentists who are legally and ethically practicing their profession in the state and are members in good standing of a component dental association, except those who fall into other categories of membership, shall **automatically** be active members of this Association, except that the active membership of each component association shall be limited to dentists practicing or residing within the territorial jurisdiction of such component association as set out in Chapter 2, Section 10, of these *Bylaws*. [Emphasis added.]

Consistent with Chapter I, Section 30 of the ADA *Bylaws*, Chapter I, Section 30 of the constituent society bylaws defines "In Good Standing" to mean:

> Any member of this Association not under final sentence of suspension or expulsion, and
>
> 1. Whose dues for the current year have been paid, or who is exempt from payment of dues by these *Bylaws*, and
> 2. Who has met such standards of continuing education as may have been established within the *Bylaws* of his/her District Association, and
> 3. Who has completed the twenty (20) hours of continuing education annually required to retain membership in the constituent society, shall be considered a member in good standing.
> 4. The requirement of paying current dues does not apply to retired life members of this Association for the purpose of determining their good standing.

Therefore, assuming a member of the constituent, such as the Appellant, satisfied the requirements of "in good standing" and was practicing legally and ethically in that state, the individual would "automatically" be an active member of the constituent. At the same time, the ADA *Bylaws* forbid component societies from adopting any bylaws that conflict with or limit the constituent society's bylaws.

Component Bylaws. The bylaws of the component society define an active member in Article III, Section 2 to mean:

> ...dentists, who are legally and ethically practicing their profession in the following [locations]...

Sections 7 and 8 of Article III provide for retired membership:

> RETIRED MEMBERSHIP may be conferred on members of this Association in good standing who retire from the practice of dentistry.
>
> PROPOSALS FOR RETIRED MEMBERSHIP shall be presented to the Board of Governors by five members. The Board, after satisfying themselves that such proposed retired member has the requisite qualifications, shall refer the candidate to the Association for ballot. An affirmative three-fourths vote of all ballots cast shall be necessary to elect.

Similar to the Association and constituent bylaws and their definition of "in good standing," there are only three ways (aside from death) in which a member of the component will cease to be a member: voluntary resignation; failure to pay dues and assessments in a timely manner; and expulsion. (Component bylaws, Article III, Section 13; Article X, Sections 4, 5 and 9; and Article XIII.) There is nothing in the bylaws providing that a member becomes a nonmember in the process of changing from one classification of membership to another. Expulsion can only occur based upon "conviction of malpractice, unprofessional conduct, violation of the Code of Ethics, or violation of the Bylaws." The Board of Governors acts as a tribunal in such cases and a two-thirds vote of the Association [membership] is required to expel a member. (Component bylaws, Article V, Section 2; Article XIII.)

When the Appellant requested a change to active membership in 1993, he was required to apply for active membership pursuant to Article III, Section 3 of the component bylaws, and that application was treated by Respondents as if it had been submitted by a nonmember. The ADA *Bylaws* require that the component bylaws neither conflict with nor limit the ADA *Bylaws* or constituent bylaws. Nowhere do the ADA *Bylaws* even suggest that a member becomes a nonmember in the process of changing from one classification of membership to another. Indeed, the Council believes that once an individual becomes a member, she or he

stays a member until resignation, nonpayment of dues, death or expulsion. The classification of that membership at any given time during the life of the member is dues driven and determined by such things as the practice or educational status, years of membership and age of the individual. Also, the constituent bylaws provide that dentists practicing in the state and who are members in good standing of their component society are "automatically" active members of the constituent.

When a bylaws provision is capable of two interpretations, one of which is valid under the Association and the constituent bylaws and the other of which is not, there is a presumption of validity and all doubts must be resolved in favor of the valid interpretation. Therefore, Article III, Section 3 could not be interpreted and enforced by Respondents in a manner that conflicted with the Association and the constituent bylaws, that is, by treating members wishing to change from retired to active status in the same manner as nonmembers applying for active membership for the first time. As happened to the Appellant in this case, such an interpretation could be used in a way to expel a member "in good standing" without the formality and protection of a disciplinary proceeding as guaranteed by the ADA *Bylaws*.

For the reasons set forth in this opinion, the Council held that the actions of the Respondents in refusing to permit the Appellant to change membership classification following his return to practice, with the result that his membership would be terminated, was in effect an expulsion from his component and constituent societies and the Association. To effect an expulsion, the component would be required by its own bylaws to conduct a hearing affording the Appellant the opportunity to defend himself and to render a decision to expel only upon approval by a two-thirds majority vote of the membership. Furthermore, under the *Bylaws* of the Association, no component or constituent society has the authority to expel a member for exercising his right to change membership classifications from retired to active status. The Council held that the action of the component society in this matter was in conflict with the ADA *Bylaws* and the Appellant should be permitted to resume active member status. The Council advised that if the Respondents wished to pursue a disciplinary action against the Appellant, that action would need to comply with the applicable bylaws requirements of their associations as well as the American Dental Association.

Response to Assignments from the 1995 House of Delegates

ADA *Bylaws* Revision: The current edition of the ADA *Constitution and Bylaws*, revised to January 1, 1996, incorporates the amendments approved by the 1995 House of Delegates.

Changes to *ADA Code*: Resolution 9H-1995 (*Trans.*1995:647) amended the *ADA Principles of Ethics and Code of Professional Conduct* (the *Code*) Principle—Section 1, SERVICE TO THE PUBLIC AND QUALITY OF CARE, to clarify the concept that the *Code* embodies a single ethical standard and that the dentist's ethical obligations are the same regardless of whether the dentist engages in fee-for-service, managed care or some other practice arrangement.

Resolution 10H-1995 (*Trans.*1995:647) amended Section 4-A, DEVICES AND THERAPEUTIC METHODS, by substituting the term *misleading* for *deceptive* for reasons of editorial consistency. These changes are reflected in the current edition of the *Code*, revised to January 1996.

Definition of "Elect" As Used in ADA *Bylaws*: Resolution 138-1995 (*Trans.*1995:607) was referred to the Council on Membership (CM), with input from the Council on Ethics, Bylaws and Judicial Affairs (CEBJA), for study and report to the 1996 House of Delegates. The resolution reads:

> **Resolved,** that the 1995 American Dental Association House of Delegates define the word "elect" as found in the *Bylaws* of this Association to mean "select" by vote.

CEBJA was informed in January that CM was conducting a survey of the constituent societies concerning the process they use to select their members and would consider Resolution 138-1995 in light of the responses received at its February meeting. CEBJA agreed that it would defer any action on Resolution 138-1995 until after CM met. CEBJA will take up the resolution at its June meeting.

Review of Association Policy: Resolution 15H-1995 (*Trans.*1995:659) calls on all agencies of the Association to review Association policy at least every seven years after it is adopted and to recommend any modifications or rescissions to the House of Delegates. The Council has identified 18 Association policies relating to ethics that it will review at its June meeting. Any recommendations for modifications or rescissions will be forwarded to the 1996 House of Delegates in the Council's supplemental report.

Response to Assignment from the 1994 House of Delegates

Review of Effect of *Code* on ADA Policies Regarding Dental Benefit Plans: The Council continued its work on implementation of Resolution 100H-1994 (*Trans.*1994:637). Resolution 100H-1994 calls for the appropriate agencies of the Association to "review the *Code* as it applies to the area of dental benefits plans, and the effect of the *Code* on Association policies regarding dental benefits plans, and report their recommendations for modification of the *Code* or any related policies of the Association regarding dental benefits plans, if any, to the 1995 House of Delegates." The Council reported to the House last year several steps it had taken to implement Resolution 100H-1994, including adoption of a statement on Ethical Aspects of Managed Care. The Council also proposed to the 1995 House of Delegates an amendment to the *Code*, Principle—Section 1, SERVICE TO THE PUBLIC AND QUALITY OF CARE, dealing with the concept of a single ethical standard, which the House adopted.

The Council determined that in order to conduct the comprehensive review of the *Code* and Association policy on dental benefits plans called for in Resolution 100H-1994, it would need the assistance of the Council on Dental Benefit Programs. A joint subcommittee made up of three members from each council was formed and met in Chicago on January 5, 1996. The subcommittee compiled a list of ethical issues implicated by the changing dental benefits marketplace. These

include patient abandonment, confidentiality of patient records, cost-shifting between patients and informed consent. The Council began its consideration of how these issues are addressed in the *Code* at its January meeting and will continue in June.

Council Activities

Review of Advisory Opinions Relating to Human Immunodeficiency Virus (HIV): By Resolution 106H-1990 (*Trans.*1990:575), the House of Delegates requested the Council to continually monitor scientific developments concerning the human immunodeficiency virus (HIV) to ensure that the Council's advisory opinions in this area remain compatible with current scientific knowledge. The Council received an update on HIV at its January meeting and determined that no changes in its advisory opinions are warranted at this time.

***Code* Reorganization:** The Council reported last year that it has undertaken the task of reorganizing the *Code* around true ethical principles. This project is nearing completion. The Council expects to present the reorganized *Code* to the 1996 House of Delegates in a supplemental report.

Editorial Changes to the *Bylaws*: The Council will also make recommendations for editorial changes in the ADA *Bylaws*. These recommendations are the culmination of a comprehensive editorial review of the *Bylaws* which the Council undertook in 1994.

Ethics Component of the SUCCESS Program: This was the second year in which the Council offered an ethics seminar for junior and senior dental students under the auspices of the Council on Dental Practice's SUCCESS program. Demand for the program exceeded available funding. The ethics seminar was presented at the following schools during the 1995-96 school year: the Medical College of Georgia, Tufts University, Columbia University, Temple University, Creighton University, Marquette University, Loma Linda University and University of California—San Francisco.

Workshop on Ethical Considerations of Managed Care: The Council presented workshops on the Ethical Considerations of Managed Care to the San Joaquin Dental Society of California on January 17, 1996 and to the Philadelphia County Dental Society of Pennsylvania on May 22, 1996.

Council Publications: The Council continues to make the following publications available free of charge to the constituent and component societies: *Guidelines for Disciplinary Hearings; Official Summary, Appellate Disciplinary Decisions of the ADA's Council on Ethics, Bylaws and Judicial Affairs;* and *Model Bylaws for Component Societies*. The constituent and component societies receive a limited number of free copies of the ADA *Constitution and Bylaws* and *ADA Principles of Ethics and Code of Professional Conduct* whenever these documents are revised. Additional copies for new members are also provided free of charge. Bulk orders by the constituent and component societies are filled for a charge that covers the cost of printing and shipping.

In January, the Council approved making the *Code* available on *ADA ONLINE*, the Association's site on the Internet. To assess the effectiveness of the distribution policies for the *Code* and *Bylaws*, the Council conducted the *1995 Survey of Distribution of Code and Bylaws* with the assistance of the Survey Center. A total of 137 executive directors from constituent and staffed component societies responded to the survey, yielding a 71% response rate. The majority of the respondents were satisfied with the distribution polices of the *Code* and *Bylaws*. A number of small constituent and component societies requested an increased number of complimentary copies of the *Code* and *Bylaws*. The Council approved an increase for these societies, consistent with available funds. Several of those surveyed were interested in receiving the *Code* and *Bylaws* on diskette. In 1996, the Council received three requests from constituent societies for the *Code* on diskette.

Golden Apple Award for Ethical Achievement: The first Golden Apple Award for Outstanding Ethical Achievement in the Promotion of Dental Ethics was awarded to the Pennsylvania Dental Association at a recognition luncheon held in conjunction with the 136th Annual Session in Las Vegas. The award recognizes a component or constituent dental society for outstanding achievement in promoting awareness of dental ethics through articles, workshops or other activities.

Subcommittee on Advertising: The Subcommittee on Advertising continues to provide advisory opinions to constituent societies on dental advertisements and their compliance with the *ADA Principles of Ethics and Code of Professional Conduct*. Constituent societies who receive a complaint about a particular advertisement may forward it to the subcommittee for analysis and a confidential opinion. This opinion is strictly advisory and is not binding on either the Council or the society that requests the opinion. The sole purpose is to provide the society with an opinion on whether the advertisement is cause for concern under the *Code*. Should the matter proceed to a disciplinary hearing which results in an appeal to the Council, members of the subcommittee do not participate in the appeal. Constituent societies are encouraged to contact the Council for further information.

Request for Guidance on Advertising Board Certification: The Council responded to a request from a national dental organization for guidance on the issue of whether the same standards apply under the *Code* to advertising directed to patients of record as to the general public. The Council agreed that advertising could be informally defined as the act of providing information about one's goods or services to someone in the hope that they will be induced by the information to purchase them. Dentists frequently provide this kind of information to their patients of record. For example, a dentist may inform his or her patients of new, expanded office hours in the hope that the patients will be prompted to make an appointment. Such communications to patients of record are advertising and subject to the same "false or misleading" standard as any other advertising.

Advisory Opinions and Proposed Amendments to the *Code*

New Advisory Opinion on Dual Degreed Dentists: At its May 1995 meeting, the Council approved working language of an advisory opinion to the *Code*, Section 5-C, ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE, dealing with dual degreed dentists. The Council approved circulation of the working language to the communities of interest for comment. All of the comments received were positive; several reviewers raised a tangential issue about whether the advisory opinion could be interpreted to condone the practice of dental specialties under a medical license. At its January 1996 meeting, the Council adopted the Report and Advisory Opinion of the Council on Ethics, Bylaws and Judicial Affairs on Dual Degreed Dentists, which is set forth below. The report makes clear that it is not the Council's intent to condone the practice of a dental specialty under a medical license. In the Council's view, the public is best served when the practice of dentistry is regulated by state dental boards.

Report and Advisory Opinion of the Council on Ethics, Bylaws and Judicial Affairs on Dual Degreed Dentists

Dual dental/medical degrees are increasingly common, particularly among oral and maxillofacial surgeons. Earning a medical degree is an integral part of the residency program in many oral and maxillofacial surgery advanced training programs in the United States. Dentists who are dual degreed in medicine and dentistry may be licensed in their respective states to practice medicine or dentistry or both.

The *ADA Principles of Ethics and Code of Professional Conduct (Code)*, Section 5-C, ANNOUNCEMENT OF SPECIALIZATION AND LIMITATION OF PRACTICE, states in part:

> Dentists who choose to announce specialization should use "specialist in" or "practice limited to" and shall limit their practice exclusively to the announced special area(s) of dental practice, provided at the time of the announcement such dentists have met in each approved specialty for which they announce the existing educational requirements and standards set forth by the American Dental Association.

In addition, Section 5-C lists three General Standards of the American Dental Association for determining the education, experience and other appropriate requirements for announcing specialization and limitation of practice. General Standard 3 states:

> 3. The practice carried on by dentists who announce as specialists shall be limited exclusively to the special area(s) of dental practice announced by the dentist.

The rule requiring dental specialists to limit their practices is justified by the need to protect the public from advertising that is false or misleading in a material respect. Patients reasonably expect that dentists who hold themselves out to the public as specialists possess a degree of expertise beyond that typically possessed by the general practitioner. Limitation of practice has long been considered a requisite to maintaining this level of expertise.

However, the Council noted that Section 5-C and General Standard 3 refer to area(s) of *dental* practice. The Council has never interpreted these sections to apply to the practice of medicine. Usually, the practice of medicine by dual degreed dentists is incidental to the dental services they render and only serves to enhance the dentist's expertise.

Of course, this may not always be the case. A dentist's medical practice might, because of its nature and the amount of time devoted to it, interfere with the dentist's ability to maintain the level of expertise patients expect of a dental specialist. The Council believes that these cases will be the exception, rather than the rule, and that they can be addressed on a case-by-case basis using the same standard that applies to all advertising under the *Code*: whether it is false or misleading in a material respect.

The Council's position on dual degreed dentists is consistent with the Standards for Multiple-Specialty Announcements found in Section 5-C of the *Code*. These Standards permit a dentist to announce in more than one dental specialty area as long as the dentist meets the educational criteria in each area in which he or she wishes to announce. Similarly, the Council believes that a dentist who has the requisite education and training should not be restricted from announcing in a dental specialty area just because the dentist also practices medicine under a valid state medical license.

In light of these considerations and the uniformly favorable response of the communities of interest to whom the advisory opinion was circulated for review and comment, the Council adopted the following Advisory Opinion 2 to the *Code*, Section 5-C, at its January 6-8, 1996 meeting:

> 2. Nothing in Section 5-C shall be interpreted to prohibit a dual degreed dentist who practices medicine or osteopathy under a valid state license from announcing to the public as a dental specialist provided the dentist meets the educational, experience and other standards set forth in this *Code* for specialty announcement and further providing that the announcement is truthful and not materially misleading.

Nothing in this advisory opinion should be construed as Council approval of the practice of dentistry under a medical license. The Council believes that the public is best served when the practice of dentistry is regulated by state dental boards.

Resolutions: This report is informational in nature and no resolutions are presented.

Council on Governmental Affairs and Federal Dental Services

Studstill, Zack, Alabama, 1996, chairman
Finley, Leo R., Illinois, 1996, vice chairman
Blodgett, Gary B., Iowa, 1997
Bushick, Ronald D., Pennsylvania, 1997
Crawford, Felix C., Texas, 1999
Crinzi, Richard A., Washington, 1998
Kennedy, Scott C., Kansas, 1998
Moody, Dennis M., Ohio, 1997
Paler, Ronald J., Michigan, 1996
Pellegrino, Dennis P., New Hampshire, 1996
Player, T. Carroll, South Carolina, 1999
Puglisi, Arthur W., New York, 1999
Rich, William K., Kentucky, 1998
Roussalis, John E., II, Wyoming, 1997
Simms, Richard A., California, 1999
Stratigopoulos, George J., California, 1996, *ex officio**
Sykes, Murray D., Maryland, 1998
Warford, John H., North Dakota, 1996, *ex officio***
Spangler, Thomas J., director
Molfese, Michelle M., manager

Meetings: The Council on Governmental Affairs and Federal Dental Services (CGAFDS) met on February 3-5 in Washington, D.C. The Council's second and third meetings are scheduled for May 31-June 2 and August 23-25 in Washington, D.C.

At the February meeting, the Federal Dental Services' chiefs of the Army, Navy and Air Force (both active duty and reservists) briefed the Council on matters of mutual interest. Also present were the chief dental officers for the Veterans Administration (VA) and Public Health Service (PHS) and the Senior Consultant for Dentistry, Department of Defense.

In addition, the Council hosted officials of related dental organizations. The officials presented their concerns about legislative and regulatory issues to the Council.

Vice Chairman: Dr. Leo Finley was elected vice chairman of the Council.

Personnel: The Council announces the addition of four new members: Dr. Felix Crawford, Texas; Dr. Carroll Player, South Carolina; Dr. Art Puglisi, New York; and Dr. Richard Simms, California. The 1996 annual session will mark the completion of the terms of service of four Council members: Dr. Leo Finley, Illinois; Dr. Ronald Paler, Michigan; Dr. Dennis Pellegrino, New Hampshire; and Dr. Zack Studstill, Alabama. The Council expresses its gratitude to these members for the exemplary manner in which they performed their duties in furthering the interests of the profession.

* Standing Committee on the New Dentist member without the power to vote.

** American Dental Political Action Committee chairman without the power to vote.

The Strategic Plan of the American Dental Association: The Council's recent activities, as described in this annual report, support many aspects of the Strategic Plan, including Objectives 1, 4, 10 and 12.

Objective 1: Legislative and Regulatory Advocacy. The Council's core function is to advise Association staff, the Board of Trustees and the House of Delegates as to the effect legislative and regulatory issues will have on dentistry. For example, at its June meeting, the Council will be studying various legislative initiatives including H.R. 2925 (the Antitrust Health Care Advancement Act of 1996) and comprehensive tax reform proposals.

Objective 4: Access to Dental Care. The Association testifies before Congress every year on the need for adequate federal funding for the Indian Health Service (IHS) dental program. In February 1996, the Association's president, Dr. William S. Ten Pas, testified in support of Fiscal Year 1997 funding for the IHS dental program before the Subcommittee on Interior and Related Agencies Appropriations, United States House of Representatives.

Objective 10: Associated Organizations. The Council promotes the use of coalitions with health care groups and others for legislative and regulatory advocacy. Recent examples include involvement with the Military Coalition (a group of 30 military-related organizations and associations whose mission is to advocate for policies that benefit military personnel and their families), the National Medical Liability Reform Coalition, the National Child Abuse Coalition and the Coalition for Health Care Choice and Accountability (CHCCA). The CHCCA, led by the Association, developed H.R. 2400, the Family Health Care Fairness Act of 1995, sponsored by Representatives Charlie Norwood (R-GA) and Bill Brewster (D-OK).

Objective 12: Constituent and Component Societies. A stated mission of the Council is to serve as a liaison with the constituent and component societies to provide information on legislative and regulatory activities and the Association's position. This activity helps to build an effective partnership, which is the intent of Objective 12. The Council has improved its liaison functions, in part through the use of the "talking points" document that was instituted last year for distribution to the constituent societies. This document informs the societies of the legislative and regulatory recommendations made by the Council at its meetings. The Council also engages in a "district activity" briefing session at its meetings. This is an opportunity for Council members to share their district experiences.

Response to Assignments from the 1995 House of Delegates

Amendments to Employee Retirement Income Security Act (ERISA): Resolution 11H-1995 (*Trans.*1995:649) requires the Association to support legislative activities designed to amend the ERISA statute in an effort to achieve greater protections for patients and providers.

The Association's activity concerning H.R. 2400 addresses this issue. H.R. 2400 amends the ERISA statute to provide greater protections for patients and providers involved with managed care organizations (MCOs). Among the protections included in the bill are:

1. consumers' choice of providers and access to plan information;
2. quality assurance measures;
3. due process for patients and providers; and
4. no discrimination against providers based on the type of license they hold.

Currently, the Association is lobbying members of Congress to have this legislation enacted into law. The Association testified on May 30 before the Health Subcommittee of the House Commerce Committee in suport of H.R. 2400.

Antitrust Jurisdiction: Resolution 13H-1995 (*Trans.*1995:648) supports legislation to eliminate the split of antitrust jurisdiction between the Federal Trade Commission (FTC) and the Department of Justice (DOJ) by placing all nonprivate antitrust enforcement within the purview of the DOJ.

The Association will support federal legislation of this nature once it is introduced in Congress. Thus far, no such legislation has been introduced in the 104th Congress.

Support for Programs that Forecast Public Demand for Dental Services: Resolution 16H-1995 (*Trans.*1995:609) supports the Association's efforts to monitor, maintain and strengthen programs that forecast public demand for dental services and which track trends in dental services utilization. Resolution 16H-1995 also requires this information to be forwarded to the appropriate Association agencies which can assess its potential impact on any state or national legislative reform proposals.

The Association, through the Division of Government Affairs, regularly reviews reports on the demand for dental services and dental services utilization. In addition, the Association assesses the impact of these reports on state and/or national legislative reform proposals. The Association will continue these activities as the resolution requires.

Legislative Delegations: Resolution 44H-1995 (*Trans.*1995:648) replaces Resolution 104H-1982 (*Trans.*1982:550), Legislative Delegations. Resolution 44H encourages Association members to join the Grassroots Program and to visit with their senators and representatives to discuss issues of importance to the profession.

To underscore the importance of the Grassroots Program to the profession, the Council will continue to encourage Association members to join the program and to be active in the political process.

Cooperation of ADA and Constituent Societies in Development of State Health System Reform: Resolution 45H-1995 requires the Association to provide assistance to the states (upon invitation) with health system reform (HSR) initiatives.

The Department of State Government Affairs (DSGA) monitors state HSR legislation, provides resource packets and provides assistance with the use of the computerized cost model offered by the Council on Dental Practice. Several states have acted on incremental insurance reforms, such as the adoption of community risk pools, portability of insurance benefits, bans on pre-existing conditions, Medicaid reforms to expand the eligible population to receive health care benefits and efforts to move the Medicaid population into managed care programs.

As of the date of this report, few constituent societies have expressed interest in the computerized cost model. This ADA-developed software enables state societies to estimate the cost of dental care for eligible populations. On the federal side, the Association received positive feedback from the Health Care Financing Administration's (HCFA) Medicaid division on the computerized cost model. Association staff met with HCFA officials this spring to demonstrate this software. The Association plans to demonstrate the software to several congressional committees, including the Senate Finance and House Commerce committees.

Tax Deductibility of Student Loans: Resolution 47H-1995 (*Trans.*1995:648) replaces Resolution 130H-1992 (*Trans.*1992:622), Tax Deductibility of Student Loans. Resolution 47H reflects the Association's support for restoring the tax deductibility of student loans as a legislative priority in every Congress. The 1992 policy stated the Association's support for this issue in the 103rd Congress.

Partial restoration of the tax deductibility of student loans was included in the Fiscal Year 1996 Reconciliation Budget Act, but the provision was vetoed by the president for other reasons. That provision would have permitted an annual deduction up to $2,500 for 60 months for those with adjusted gross incomes below $45,000 for individuals and $65,000 for married joint filers. This issue continues to be a priority of the Association.

Antitrust Reform Relying on Market Power: Resolution 49H-1995 (*Trans.*1995:648) supports legislative and regulatory activities to change the current antitrust safe harbor guideline for dental networks based on percentage of provider participation in favor of a guideline relying on market power.

ADA leadership met with the FTC in December 1995 and urged the agency to consider amending the definition of a safe harbor to include dental Independent Practice Associations (IPAs) with high provider participation but without significant market power. Written comments were also provided to the FTC outlining this position and several additional antitrust concerns. The Association also met with the FTC in April 1996 to provide recommendations on the expected clarification of the FTC/Justice guidelines on the formation of provider networks that are due some time this summer.

Requirements for Managed Care Programs: Resolution 57H-1995 (*Trans.*1995:627) identifies the minimum requirements for MCOs that the Association advocates in the federal legislative and regulatory arenas.

The Council conducted a comprehensive review of H.R. 2400 and Resolution 57H-1995 and determined that many of the elements contained in 57H-1995 not specifically addressed in H.R. 2400 should be lobbied for within the context of the Association's lobbying effort on the bill. The Association testified before Congress on concerns regarding "managed care organizations" on May 30, 1996, at which time it advocated H.R. 2400 and Resolution 57H-1995 issues. That testimony, as well as ongoing lobbying efforts on H.R. 2400, will address the positions stated in Resolution 57H-1995.

The DSGA maintains a current list of patient/provider options, sample state laws/regulations addressing various aspects of managed care, strategies and relevant background materials and has offered these resources to constituent societies. There is a tendency for legislators to be more willing to enact laws favorable to patients/consumers than to alter the contractual relationships between providers and third-party payers, although providers have gained statutory protection from certain practices of managed care organizations in some states.

Information on Calculation of Benefits: Resolution 74-1995 (*Trans.*1995:648) states the Association's belief that all beneficiaries are entitled to know the basis upon which their benefits are calculated, whether covered by an insured plan or by an ERISA plan. Resolution 74-1995 also requires the Association to pursue legislative or regulatory changes to assure the patient's right to this information on a timely basis.

Resolution 74-1995 was referred to the Council on Dental Benefit Programs (CDBP) for action, with input from the CGAFDS. At its February meeting, the Council strongly endorsed this resolution, noting that H.R. 2400 requires all health plans (insured and self-funded) to provide expansive amounts of plan information to beneficiaries. Subsequent to the meeting, the Council Chairman sent a letter through the Executive Director to the CDBP expressing the CGAFDS' support for the resolution. The CDBP will provide a complete response to Resolution 74-1995 in a supplemental report to the House of Delegates.

In addition, in December 1995 ADA representatives met with the Assistant Secretary, Pension and Welfare Benefits Administration, Department of Labor, to request that the agency require self-funded plans (which are governed by ERISA) to provide a more accurate explanation of benefits to plan beneficiaries. The agency responded in March 1996 that ERISA regulations already require a description of benefits that the average participant can understand. The agency also stated that it recognized the disclosure of information "...is an especially important issue and we appreciate your insightful comments." Finally, the department said it continues to look for better ways to address the concerns of participants and beneficiaries and will consider the ADA's suggestions with regard to any future actions.

The Council also recognizes this activity is already occurring at the state level. For instance, the DSGA has encouraged states to pursue legislation to give patients the right to know specific information about their health insurance coverage and the limitation contained in the plans. The enactment of Usual Customary and Reasonable (UCR) legislation is an example of a type of law which furthers this policy. Six states have enacted UCR legislation or regulations.

Nicotine as an Addictive Substance: Resolution 86H-1995 (*Trans.*1995:609) supports legislation and/or regulation that acknowledges nicotine as an addictive drug and that authorizes the Food and Drug Administration (FDA) to regulate tobacco products as nicotine delivery devices and/or drugs. Resolution 86H-1995 also requires that such legislation and/or regulations be promptly enacted so that the use of nicotine is restricted.

In December 1995, President Clinton authorized the FDA to regulate the use of tobacco products by children. During public comment on the proposed regulation, the Association submitted comments to the FDA in support of this regulation.

Administrative Practices Encouraging Dentist Selection Based on Cost: Resolution 93H-1995 (*Trans.*1995:610) requires the Association to take appropriate legislative action to oppose any administrative practice or financial incentive that is utilized by benefit managers and/or administrators of dental prepayment plans to force or otherwise encourage patients to select the dentist from whom they will seek care principally on the basis of cost.

At the federal level, the Association is promoting this resolution in its advocacy of H.R. 2400. One of the central principles of H.R. 2400, the mandatory point-of-service (POS) option, ensures that patients who are in managed care plans are guaranteed freedom of choice in selecting their health care providers. A POS option is an out-of-network benefit that allows enrollees to elect to receive care from providers outside their plans. H.R. 2400 also establishes protections for providers who elect to participate in managed care plans to ensure that the selection is not based solely on cost factors associated with the manner in which a provider practices. At the state level, the constituent societies are encouraged to consider taking appropriate action to achieve this policy.

Opposition to Interference in Patient's Freedom of Choice of Dentist: Resolution 94H-1995 (*Trans.*1995:631) directs the Association to actively pursue legislation that will guarantee the patient's right to choose any licensed dentist to deliver his or her oral health care without any type of coercion. Resolution 94H-1995 also requires the Association to take legislative action to oppose any arrangement that eliminates, interferes with or otherwise limits the patient's freedom of choice.

At the federal level, the Association is advocating H.R. 2400, which includes the mandatory POS option. As described above, the POS option is designed to ensure freedom of choice of health care provider. On the state level,

the DSGA has considerable information on state laws and regulations that promote freedom of choice and has offered to assist the constituent societies in enacting freedom of choice laws. Several states have requested this information.

Review of Association Policy on Taxation of Dental Benefits: Resolution 95H-1995 (*Trans.*1995:610) requires the Association to review its policy opposing the taxation of dental benefits to employees or the loss of tax deductibility of the costs of dental benefit plans to purchasers. Resolution 95H-1995 also requires the review to weigh the economic impact of this change of policy on practicing dentists versus the health benefit of returning the responsibility of dental care to the patient and the elimination of any interference by outside agencies in the doctor-patient relationship.

The Council has worked on this issue with the CDBP, which has primary jurisdiction. At this time, the Council recommends the continuation of the Association's current position because there is no compelling fiscal reason for changing, and because such a radical change in a long-standing position without sufficient rationale could undermine the ADA's credibility with Congress. However, the Council will be conducting a more comprehensive analysis of this issue at its June meeting in anticipation of significant tax reform activities in Congress beginning in 1997.

Dentistry as an Independent Profession: Resolution 98H-1995 (*Trans.*1995:640) states that dentistry should continue to be a profession of its own and should not become a medical specialty.

A work group of the Council is studying Resolution 98H-1995 for a report to the full Council at its June meeting. A response to this resolution will be reported in the Council's supplemental report to the House of Delegates.

States' Rights Affecting the Practice of Dentistry: Resolution 100-1995 (*Trans.*1995:649) states that the American Dental Association supports the authority of each state government to adopt and enforce laws and rules that regulate the practice of dentistry and enhance the oral health of the public within its jurisdiction.

A work group of the Council is studying Resolution 100-1995 for a report to the full Council at its June meeting. A response to this resolution will be reported in the Council's supplemental report to the House of Delegates.

Legislative Separation of Medicine and Dentistry: Resolution 106-1995 (*Trans.*1995:649) requires the American Dental Association to work to assure that dentistry is addressed separately in any legislation that affects health care, rather than be included as a part of medicine.

A work group of the Council is studying Resolution 106-1995 for a report to the full Council at its June meeting. A response to this resolution will be reported in the Council's supplemental report to the House of Delegates.

Rescission of Policy on Dental Society Participation in Program Planning: Resolution 113H-1995 (*Trans.*1995:648) replaces Resolution 33H-1966 (*Trans.*1966:336), Dental Society Participation in Program Planning. In addition, the resolution urges the constituent and component societies to actively participate in planning and preparation of all programs involving dental health benefits which may be sponsored by public agencies at any level.

The DSGA encourages constituent societies to work with state agencies and legislative bodies in planning and designing public programs involving dental health benefits. Part of this effort includes a cooperative effort with the Division of Dental Practice in offering constituents a computerized cost model for determining the costs of state health services.

Rescission of Policy on Health System Reform—Medicaid: Resolution 114H-1995 (*Trans.*1995:648) replaces Resolution 104H-1993 (*Trans.*1993:665), Health System Reform—Medicaid. Resolution 114H-1995 urges that any HSR plan that is passed by Congress guarantees dental care for those categories of people eligible under Medicaid at the time the legislation is passed.

The Council notes this clarification and has directed the staff to act accordingly.

Rescission of Policy on Improvements in Medicaid Program: Resolution 115H-1995 (*Trans.*1995:648) replaces Resolution 106H-1989 (*Trans.*1989:559), Improvements in Medicaid Program. Resolution 115H-1995 states that constituent societies, in cooperation with the Association, be urged as a priority item, to seek uniform benefits, adequacy of payments and voluntary practitioner participation and then seek expansion of Medicaid benefits for all segments of the indigent population.

The DSGA offers its assistance to states with the computerized cost model for single-payer dental plans, resource packets on Medicaid and health system reform. The Department also offers on-site assistance for development of arguments and strategy.

Community Rating, Risk Pools and Portability: Resolution 116H-1995 (*Trans.*1995:648) directs the Association to endorse the concepts of community rating, risk pools for small employers and individuals and portability of health benefit coverage plans in federal legislation.

During the 104th Congress, the Association supported incremental HSR legislation, known as the "Health Coverage Availability and Affordability Act of 1996." In essence, the legislation would improve portability of health insurance; place limits on exclusions for preexisting conditions; guarantee renewability for groups and individuals; and make health insurance more accessible to small businesses. (For further information refer to the **Health System Reform** section under **Other Council Activities.**) On the state level, the DSGA monitors state legislative activity in this area and has observed a significant increase in the number of states which have introduced and enacted such laws this year.

Prohibition of Contract Provisions Permitting the Automatic Assignment of Participating Dentist Agreements Among Entities Engaged in the Business of Insurance: Resolution 117H-1995 (*Trans.*1995:648) requires that the Association initiate legislative and/or regulatory actions to prohibit PPO brokers and third-party payers in contractual relationships with dentists from selling and/or using the discount rate information about those dentists to any other third-party payers and/or extended managed care networks. Resolution 117H-1995 also requires that the Association

encourage state dental societies to initiate legislative and/or regulatory action to prohibit these practices on a state level.

The Association advocates this resolution within the context of H.R. 2400 and other managed care issues. On the state level, the DSGA has compiled information on laws and regulations prohibiting the operation of so-called silent preferred provider organizations and has offered to assist constituent societies with information and supporting arguments. No state has requested this information to date.

Support for the Existence of the Office of the U.S. Surgeon General: Resolution 118H-1995 (*Trans.*1995:648) requires that the Association support the existence of the Office of the U.S. Surgeon General (OSG).

Funding for the OSG position was threatened in the Fiscal Year 1996 federal appropriations process. The Association sent a letter to Congress and lobbied in support of the position, stating its importance to national public health issues and the Chief Dental Officer position within the PHS. The OSG position was funded in the FY 1996 Labor, Health and Human Services and Education appropriations bill.

Family Health Care Fairness Act of 1995: Resolution 119H-1995 (*Trans.*1995:650) directs that for the benefit of the oral health of the American public the Association:

1. immediately initiate an aggressive lobbying campaign in Congress to advance the provisions of "The Family Health Care Fairness Act of 1995" as originally introduced;
2. compile data on the effects of managed care on the oral health of the American public including, but not limited to, the effects of managed care on the cost, accessibility and quality of oral health care; and
3. develop strategies through its appropriate agencies to introduce legislation concerning requirements governing managed care and that from the above data a lobbying campaign message be immediately developed emphasizing the effects that the objectives and ramifications of managed care have on the oral health of the American public.

The Council notes that the study called for in this resolution is being addressed in conjunction with Resolution 62H-1995 (*Trans.*1995:619). A Board-appointed coordinating committee is spearheading the study. The lobbying campaign referred to in Resolution 119H-1995, however, is being implemented by the Association's Division of Government Affairs. The Council is providing general guidance and oversight to the Division of Government Affairs concerning the implementation of this resolution. A separate report to the 1996 House of Delegates will detail the Association's activities in both of these areas.

The Association began an aggressive lobbying campaign in support of H.R. 2400 immediately following the 1995 annual session. At that time, the Association sent a "call to action" letter to the Grassroots network. In addition, the Association, through the grassroots newsletter *The Advocate*, initiated a cosponsor drive in an effort to assist Congressmen Norwood (R-GA) and Brewster (D-OK) to gather additional support for the bill. The cosponsor drive will continue with each edition of *The Advocate*, along with targeted grassroots district meetings, Council member involvement and individual lobbying efforts by the Washington Office.

Recently, the Association was invited to testify in support of H.R. 2400 as part of a larger hearing devoted to managed care issues. The Association testified before the Health Subcommittee of the House Commerce Committee on May 30 and held a press conference prior to the hearing.

In addition, the Association has taken every opportunity to advance the principles contained in H.R. 2400. When incremental HSR legislation was moving through the legislative process, the Association sent numerous communications to Capitol Hill urging the inclusion of federal protections for patients and providers involved with MCOs.

Finally, the ADA-led coalition supporting H.R. 2400 has been active on many fronts. Its publicity subcommittee is working to compile media kits which will be sent to an extensive range of press representatives, as well as assorted trade associations and consumer groups. The coalition's outreach subcommittee has contacted numerous associations, consumer groups and other interested parties in an effort to broaden the base of support for the bill. The current list of organizations supporting H.R. 2400 numbers over 50. The Association will continue its multifaceted lobbying activities to gain enactment of this bill into law.

Prohibition of Hold Harmless Clauses: Resolution 120H-1995 (*Trans.*1995:651) directs that the Association initiate the development of federal and, upon request, state legislation necessary to prohibit the inclusion of "hold harmless" clauses in managed care provider contracts, to the extent that such clauses seek to shift managed care plans' liability to dentists for adverse patient care outcomes due to actions taken by plans pursuant to contractual provisions or restrictions. Resolution 120H-1995 also requires the Association to continue its educational efforts to help dentists make informed, individual decisions about signing managed care plan contracts.

The Association advocates this issue within the context of H.R. 2400 and included it in the Association's May 22 testimony to Congress. At the state level, the DSGA monitors state legislation to ban inclusion of "hold harmless" clauses in managed care provider contracts and has offered to assist states interested in enacting similar legislation. At least two states, New Hampshire and California, enacted hold harmless bans in 1995, and Virginia thus far in 1996.

Regulation of Amalgam Discharge to Wastewater: Resolution 121H-1995 (*Trans.*1995:651) requires that the Association take steps to ensure that federal regulations potentially affecting the discharge of amalgam to wastewater are based upon sound science. Additionally, Resolution 121H-1995 states that the Association adopt a strong proactive advocacy program to convince the EPA that, based on current scientific evidence, there is no legal basis for including amalgam waste from dental offices in its regulation of wastewater and sludge. Considering current scientific evidence, this advocacy may include, but not be limited to, the following goals:

1. that any regulation recognize the difference between organic and inorganic mercury;
2. that metals criteria for mercury be based on the understanding of dissolved and particulate metals;

3. that EPA regulations should take into consideration current scientific evidence that indicates amalgam in sludge does not dissociate in sewage treatment facilities; and
4. that a federal exemption be sought for dental amalgam from pretreatment regulation.

The ADA's Water Quality and Waste Management Task Force met in February and May 1996 to discuss the status of the Association's implementation of Resolution 121H. ADA representatives met with EPA Region V officials on April 25 at the agency's invitation to discuss matters relating to implementation of Resolution 121H and possible voluntary, cooperative efforts between Region V and dentists.

Region V's letter of invitation mentioned that the agency had already met with state environmental officials and has set up various task forces and teams through which EPA seeks to work cooperatively with affected parties, including dentists. EPA staff repeatedly indicated their focus was on cooperative efforts and voluntary, not mandatory, measures.

The Association requested the opportunity to meet with EPA headquarters officials to present the ADA's scientific information on dental amalgam and emphasize that the Association believes the agency's actions must be based on sound science.

Medicaid Block Grants: Resolution 128H-1995 (*Trans.*1995:651) requires that if the block grant concept for funding Medicaid becomes law, a designated portion of the block grant be allocated for dental care. The resolution also encourages constituent societies to initiate legislation to mandate that a designated portion of the block grant be allocated for dental care.

At the federal level, comprehensive Medicaid reform continues to be a legislative priority in the 104th Congress. The Association has been lobbying several issues including preservation of the full range of coverage and services under the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program for children. House leaders are hopeful that concerns over the formula for funding and entitlements can be resolved sometime this year.

Although Congress has not enacted comprehensive Medicaid reform, the DSGA has encouraged and assisted constituent societies in a variety of ways, including furnishing legislative resource packets and, in cooperation with the Division of Dental Practice, offering to assist constituents in gathering information to be used in working with state officials on dental services under Medicaid waivers or other reforms. The Department also encourages constituent societies to establish and maintain continuing relationships with state Medicaid officials to ensure that dental services are provided for in any reform plans.

Rescinded Policies: The following 1995 resolutions were adopted to rescind several Association policies. These policies have been removed from the latest edition of *Current Policies*.

Family Shelter Program. Resolution 43H-1995 (*Trans.*1995:648) rescinds Resolution 18-1960-H (*Trans.*1960:216), Family Shelter Program.

Safety in Drug Packaging. Resolution 46H-1995 (*Trans.*1995:648) rescinds Resolution 109H-1982 (*Trans.*1982:552), Safety in Drug Packaging.

Registration of Health Care Providers. Resolution 48H-1995 (*Trans.*1995:648) rescinds Resolution 110H-1982 (*Trans.*1982:550), Registration of Health Care Providers.

Health System Reform—Cost Containment and Health Insurance Simplification. Resolution 50H-1995 (*Trans.*1995:648) rescinds Resolution 103H-1993 (*Trans.*1993:665), Health System Reform—Cost Containment and Health Insurance Simplification.

Update on Federal and State Issues

The Council provides oversight and general guidance to the Division of Government Affairs staff concerning legislative and regulatory activities. At present, the Council is involved with the following federal and state legislative and regulatory issues.

Federal Issues

Health System Reform: The second session of Congress is proving to be an exciting one for the HSR issue. Unlike the 1994 debate that centered around comprehensive reform, the 1996 debate is far less sweeping. As of late May, the House and Senate passed differing proposals of the HSR legislation. A conference committee will be named to reconcile the differences in the two proposals. The main components of the proposals would improve portability of health insurance, place limits on exclusions for preexisting conditions, guarantee renewability for groups and make health insurance more accessible to small businesses. It is important to note that the two proposals do not apply to dental-only health plans.

During every stage in the legislative process, the Association advanced additional Association-supported issues including medical savings accounts (MSAs), greater protections for providers and patients under ERISA, medical malpractice and increasing the tax deduction for the self-employed.

MSAs. The Association was successful in obtaining favorable MSA language in the House proposal. The provision would:

- provide participating individuals the opportunity to use their MSA funds for all noncovered dental services; and
- maintain the tax deductibility of dental benefit plans purchased separately from the MSA-catastrophic plan.

The Senate bill does not contain any MSA provisions. The White House has expressed opposition to MSAs, claiming that they draw healthy individuals from existing health plans. The end result would be an increase in the cost of health insurance for the sickest people. A number of Democratic and Republican senators oppose the MSA provision as well and support passage of more modest bipartisan reform efforts. Nonetheless, the Association will be working to include

MSAs in the final legislation for President Clinton's signature.

Medical Malpractice. The House proposal contains medical malpractice provisions long supported by the Association. The provisions would cap noneconomic and punitive damage awards, limit joint and several liability claims, allow for periodic payment of future awards and limit plaintiff lawyer fees by a sliding scale. The President has said that he will veto any HSR bill which contains these provisions. The current Senate bill does not contain medical malpractice provisions. The Association will be lobbying to ensure that the final legislation includes favorable medical malpractice reform.

Tax Deductibility for the Self-Employed. Both the Senate and House proposals include raising the tax deductibility of health insurance for the self-employed. The Senate bill increases the deductibility from the current level of 30% to 80%. The House bill increases it to 50%. Association policy supports raising this tax deduction to 100%.

Patient/Provider Protections. The House proposal expands ERISA coverage without providing uniform national standards necessary to ensure adequate consumer/patient protections. In a formal letter to every House member, the Association emphasized its opposition to expanding ERISA in this manner. The ERISA features of the legislation are supported by numerous small-business groups, including the National Federation of Independent Businesses. The Senate bill contains only market insurance reform provisions—without the objectionable ERISA expansions—and does not provide for MSAs, an increased tax deduction for self-employed business owners, or medical malpractice reform. The President has indicated that he supports this bill over the House's more expansive HSR proposal.

Occupational Safety and Health Act (OSHA) Reform: Prospects for H.R. 1834, the House OSHA Reform legislation strongly supported by the Association, are now diametrically different from earlier this year. On February 29, Association president Dr. William S. Ten Pas met with House Workforce Protections Subcommittee Chairman Cass Ballenger (R-NC) to confirm increasing concerns that GOP leadership had decided to postpone any further consideration of H.R. 1834 for the immediate future. Many House members who had previously gone along with strong OSHA reform have ultimately backed away from the issue, fearful that their reelection could hinge on avoiding such controversial votes. Indeed, Representative Tom DeLay (R-TX), one of OSHA's strongest critics, has privately admitted that the bill will not be brought up unless passage is assured—and the votes are not there.

Meanwhile, on March 5, the Senate Labor and Human Resources Committee approved S. 1423, its own OSHA reform bill. The final vote was 9-7 along party lines. The measure would codify the phone/fax inspection system that OSHA established with the Association and would eliminate random health inspections for small employers. Despite President Clinton's express statement that he would veto this bill and reluctance by House leaders to move on OSHA Reform, Committee Chair Nancy Kassebaum (R-KS) is pushing for a May vote on the legislation.

Increased Compensation for Active Duty Dentists and Dentists in the Reserve Components: The Association was successful in getting the House National Security Committee and Senate Armed Services Committee to include a provision in their respective Fiscal Year 1996 Department of Defense Authorization bills that would:

- increase special pay for junior officers in the active duty dental corps (an average of $3,600 per year);
- create a $30,000 accession bonus for dentists entering the military; and
- reestablish special pay for dentists in the reserve components (pay to be provided during the period of time the reservist is on active duty).

In addition, the Senate version includes an Association-supported provision that establishes a dental benefits program for military retirees. The Association will continue its lobbying activities as the legislation moves to the House and Senate floor and into conference. The final outcome of this legislation will be reported in the Council's supplemental report to the House of Delegates.

Regulatory Reform: On March 29, President Clinton signed into law the debt limit bill, H.R. 3136, which contains regulatory reform legislation. The measure allows Congress to review all new agency rules before they are implemented. If Congress believes that proposed rules are flawed, it will have 60 days to overturn them. The Association worked with Senator Don Nickles (R-OK) on this provision last year.

Oral Health Focus: The Association is concerned about the apparent erosion of dentistry's position within federal health agencies. Due to budget constraints, many of these agencies, including the Health Resources and Services Administration (HRSA) and the Centers for Disease Control (CDC), are being forced to make organizational decisions that may not be in the best interests of the public. The Association and the American Association of Dental Schools (AADS) met with HRSA on several occasions to express their concerns in this area. A joint letter was sent to HRSA on behalf of the Association and the AADS outlining the specific issues. The Association has also submitted written information and participated in a day-long focus group this spring in connection with an outside study of HRSA. The study, which is being conducted by the National Academy of Public Administration, will recommend ways to reorganize the agency to better serve its constituencies in an era of scarce resources. In this same vein, the ADA President, President-elect and Executive Director, along with Washington Office staff, met with CDC staff to discuss the loss of division status for the Oral Health group. A two-track approach, with lobbying at the administration and congressional levels, is being undertaken to address both the HRSA and CDC problems.

Hazard Communication: The National Advisory Committee on Occupational Safety and Health (NACOSH) is reviewing OSHA's Hazard Communication Standard with an eye to making it more effective and less burdensome. The Association testified in support of such a proposal in the fall of 1995 and submitted several written comments to the agency. The NACOSH work group reviewing the standard is

preparing to recommend to OSHA that it try to lighten the load on very small employers through "enlightened enforcement policy." Representatives of small employers, including the Association, had pressed for a flat-out exemption from the standard. This would require a new rule to be made, which OSHA is determined to avoid and the review group is reluctant to recommend.

Proposed Rule on Recording and Reporting of Occupational Illnesses and Injuries: OSHA issued a proposed rule on February 2, 1996 that would overhaul the recording and reporting procedures of occupational illness and injuries. It is the first major overhaul of its kind since 1971. Under the proposed rule, most dental offices are exempt (about 98%). The Association will be submitting comments to address a number of its concerns and express strong support for the exemption.

Ergonomics: Although an ergonomics rule is highly unlikely to be made this year, the Association is closely monitoring the situation. The Association continues to participate actively in the pro-business National Coalition on Ergonomics to monitor the development of a voluntary consensus standard under the umbrella of the American National Standards Institute and to analyze OSHA's new record-keeping proposal for any ergonomics implications.

State Issues

Dental Hygiene: In 1995, three more states—Arkansas, Nebraska and South Carolina—moved to permit dental hygienists to administer local anesthesia; North Dakota became the 29th state to approve general supervision; and Nevada now allows unsupervised practice on patients of record in institutional settings.

In 1995, hygiene-backed legislation on local anesthesia failed in Florida and Texas, as did unsupervised practice in Indiana, Montana, Oregon and Washington. A separate hygiene board bill also failed in Montana, and the Oregon bill would also have given authority to hygienists to supervise dental assistants.

Most of the 1996 bills and those still pending from last year concern the issues of supervision and administration of local anesthesia.

General supervision was defeated in 1996 in Georgia, and unsupervised practice in certain institutional settings was regarded as unlikely to pass in California, Connecticut, Illinois and New York.

Bills introduced or pending in 1996 in at least seven states would change the law to allow dental hygienists to administer local anesthesia or nitrous oxide. As of late April, the bills were defeated in Florida, Indiana and Virginia and were opposed by the dental societies in the other states. Twenty-two states currently allow dental hygienists to administer local anesthesia and 16 permit them to administer nitrous oxide.

Denturism: Legalized practice of denturism is still permitted in only six states. A Mississippi voter initiative on denturism failed in 1995. Denturists in Maine sought their own licensing board because they could not meet the current qualifications for practice that were set by the dental board. The legislature did not give them their own board but did pass a law earlier this year that requires the dental board to formulate rules, sets eligibility requirements for taking the denturist examination and provides for mandatory continuing education and licensure by endorsement. Denturists must obtain a statement of oral conditions dated and signed by a licensed dentist within 30 days prior to treating a patient.

Bills to legalize denturism were introduced in 1996 in Florida, Kentucky and Mississippi; all failed.

Licensure: Early this year, Colorado became the first state in nearly two years to introduce a bill to grant licensure recognition without examination to dentists licensed in other states. Twenty-nine states and District of Columbia grant licensure recognition by credentials or reciprocity.

A new law in Oklahoma gives the board more discretion to license dentists and specialists by credentials. A Washington bill would add a description of oral and maxillofacial surgery to the definition of dentistry.

A requirement to carry malpractice insurance as a condition of licensure, currently required of dentists only in Florida, is pending in Michigan and Washington. Washington used to have such a requirement, but repealed it.

Conduct/Discipline: Acceptance of referral fees by dentists is prohibited by 1995 laws enacted in Alaska and Louisiana. A California law forbids dentists from using voluntary school health screenings as a way of soliciting patients.

Waiver of copayment without disclosure to third-party payers is now regarded as unprofessional conduct in Louisiana and Kansas. To date, there are 18 states with similar laws, but last year Illinois deleted a provision outlawing waiver of copayment from its practice act.

Provider Taxes: Thanks in large part to the efforts of the South Dakota Dental Association, a 4% tax on providers was defeated in 1995.

Dental Benefits/TMJ: North Carolina and Virginia passed TMJ laws in 1995, bringing to 16 the number of states having such laws. North Dakota increased the lifetime benefit to $10,000 for surgery and $2,500 for nonsurgical treatments.

Another big push for TMJ laws is underway in 1996. At least nine states have some form of TMJ legislation pending this year. Insurance coverage for cleft lip and palate and other craniofacial abnormalities is addressed in bills pending in Pennsylvania and Vermont. Both bills would prohibit health insurance companies from excluding coverage for craniofacial disorders. A North Carolina bill would appropriate funds to provide diagnostic and treatment services for uninsured children with cleft lip and palate.

Antitrust: At least four states—Montana, North Carolina, North Dakota and Wyoming—eased the way for formation of cooperative agreements among health care providers by providing protection from state and, in some cases, federal antitrust scrutiny in 1995.

Usual, Customary and Reasonable Fees (UCR)/Utilization Review: Iowa enacted a UCR law in 1995, raising the number of states with UCR legislation to six. Also last year, utilization review requirements were modified in other states. In California, utilization review agents cannot be compensated based upon the number or cost of claims denied; Indiana requires claim reviewers to prepare a written notification of

determinations for both the enrollee and provider; and Virginia now requires independent final appeals, to be conducted by a peer of the treating provider.

In 1996, regulation of utilization review organizations and agents was proposed in South Dakota. An Illinois bill makes MCOs and utilization review agents liable for all damages resulting from a denial or limitation of health care services.

Assignment of Payment: A 1995 Alabama law authorizing patients to assign payment for services directly to their health care provider does not apply to employer-funded self-insured health plans which are governed by federal law (ERISA), according to a federal district court ruling in 1996. Several states have assignment of payment laws, but these laws differ from Alabama's because they are not intended to apply to ERISA-based plans.

Assignment of payment bills were introduced this year in Hawaii, New Jersey, South Carolina and Tennessee.

Medical Savings Accounts: In 1995, MSA bills were enacted into law in about 15 states, and bills are pending in at least as many states in 1996.

Managed Care: Complaints from consumers and providers of health care services over some practices of health maintenance organizations (HMOs) and other MCOs prompted state legislatures to take action to curb some of those practices, particularly this year. Pending legislation addresses the following specific aspects of managed care plans.

Freedom of Choice. A number of bills were introduced in 1995 to give patients freedom of choice of providers. Most failed, but Maryland did enact legislation. In 1996, there are bills in Florida, South Carolina and Tennessee.

Any Willing Provider. In 1995, any willing provider legislation was enacted in Alabama, Arkansas, Mississippi, Nebraska and Wyoming. California and New York are two states that have any willing provider bills pending this year. These bills would allow any providers in the geographic service area to apply for credentials and enter into agreements with an MCO if they are willing to meet the terms and conditions.

Patient/Provider Protection. At least four states—Maryland, Mississippi, Nebraska and Oregon—enacted fairly comprehensive laws generally described as patient/provider protection laws last year. These laws contain elements of freedom of choice, any willing provider and due process protections for patients and providers.

In general, legislation emphasizing patient protection fared better than provider protection. But providers benefited from 1995 laws enacted in these states: Indiana granted due process rights to providers who contract with HMOs and West Virginia's HMO law now specifies that dentists, not physicians, are the coordinators of dental care for HMO patients. Both California and New Hampshire limited the extent to which HMOs or health service plans could require indemnification from providers. Both states now restrict the contracts between plans and providers from indemnifying or limiting the liability of the plan which would otherwise be legally responsible. Louisiana enacted legislation to ensure that any provider who provides emergency services to HMO patients can be paid, whether or not they are participating providers.

Due process rights for health care providers can mean anything from the right to obtain information about selection criteria utilized by MCOs to a full-scale hearing before being terminated (deselected) from the plan. In 1996, legislation was enacted in Georgia, and, as of April, bills were pending in Illinois and New Jersey.

Point-of-Service Option. The POS option permits patients in managed care plans to choose a doctor outside the network as long as the patient is willing to pay the cost differential out-of-pocket. New York adopted a POS option for HMO enrollees late last year. This year, POS options were enacted in Georgia, Virginia and Washington. Similar bills were pending in 1996 in Illinois, Indiana, Iowa, Kentucky, New Jersey and North Carolina.

Ban on Gag Clauses. "Gag clauses" are contractual clauses that prevent health care providers in MCO plans from discussing treatment options, plan policies and limitations regarding plan coverage with patients prior to receiving authorization from the MCO. Such restrictions could interfere with the doctor's ethical and legal duty to provide patients with valuable information about treatment benefits, costs and risks. These restrictions could also expose doctors to malpractice claims. Representatives of MCOs refer to these as "confidentiality clauses" and say that restrictions are intended to protect trade secrets and proprietary information.

Massachusetts has enacted what is believed to be the first state law that prohibits insurers, including MCOs, from using gag clauses. Georgia, Virginia and Washington followed soon after. Gag clause bans are also the subject of pending legislation in 1996 in Indiana, Maine and New York.

Information Disclosure. One of the major objections to managed care plans is the inability of patients to obtain specific information about the plan and the extent of benefits coverage. In addition to enabling the patient to gather this information from the health care provider by prohibiting gag clauses, there are other bills requiring various types of information (e.g., plan limitations, financial incentives to providers to keep referrals down) to be disclosed by the insurer or MCO to prospective insured patients. Virginia enacted a provision of this type early in 1996. Bills are pending this year in Florida and Illinois. New Jersey planned to issue regulations in midyear to require HMOs to disclose physician incentives and tell consumers if compensation arrangements with physicians are tied to utilization.

Ban on Limiting Necessary Care. While the above legislation would require disclosure of certain information, a 1996 law enacted in Georgia (and bills pending in Illinois and New York), aims to prohibit MCOs from making payments to providers as an inducement to reduce or limit medically necessary and appropriate services. Texas insurance regulations applicable to HMOs and Preferred Provider Organizations (PPOs) require them to allow patients to go out-of-network to obtain medically necessary services when covered services are not available from network providers. An Illinois bill requires MCOs to give each enrollee access

through the provider network to the full range of dental services that are included in the insured's benefits package.

Regulation of Risk-Bearing Entities. The National Association of Insurance Commissioners (NAIC) has for several years been in the process of drafting model legislation to regulate and license all health care entities that assume financial risk regardless of the formal structural arrangement. Georgia, for example, enacted a law in 1996 that requires the registration of all MCOs, and Ohio announced plans in midyear to license all managed care plans that assume risk. Ohio dentists are concerned that such legislation would set unreasonably high financial reserve requirements for dental IPAs. Tennessee is another state with pending legislation that would prohibit all unauthorized entities from assuming insurance risks.

Limited Liability Companies: A flurry of activity in this area concerned bills either to allow the formation of Limited Licensed Partnerships or Companies (referred to as LLCs) or amendments to those laws that would enable health care providers to enter into such arrangements to carry on their practices. Although relatively few were enacted, the 1995 Louisiana law is noteworthy in that it specifically applies to dentists, and in Nevada, an LLC can be organized by just one person.

Ownership of Dental Practices/Employment of Dentists: As a general rule, most states ban the corporate practice of dentistry, except where licensed dentists form a professional service corporation and incorporate under state law to conduct their practice. Most of these provisions were written long before there was much interest in managed care and before integrated health care systems gave rise to new types of structured business arrangements. An unusual provision in the North Dakota dental practice act, enacted in 1995, permits a dentist to own majority control of a practice, but just barely. Nondentists can own up to 49% of the practice.

The threat of outside interference with professional judgment is an increasing cause for concern. Two states, Nebraska and Utah, moved quickly in 1996 to address the issue. A Nebraska law prohibits employers from coercing health care professionals to practice in any manner contrary to their professional judgment. Utah now makes it unlawful to interfere with a dentist's judgment and bans bringing unlicensed dentists into the practice to direct or otherwise interfere in the practice. The law goes on to specify the business forms of practices under which a dentist may organize.

The question of whether a particular type of structured practice arrangement does or does not violate a legal requirement that only a licensed dentist can own, operate or manage a practice is a vexing question for dental boards.

In March of this year, the Mississippi State Board of Dental Examiners established a policy on the corporate practice of dentistry, effective in April. Essentially, the board decided *not* to concern itself with the form or type of business arrangements entered into by a licensee, but listed criteria which focused instead on the role and actual conduct of the dentist under the arrangement.

It is important to note that there are exceptions to the general rule of dental ownership of practices. Most states permit a family member or the estate of a deceased dentist to carry on the practice for a limited period of time. A 1996 Kansas bill says that an estate or agent for a deceased or disabled dentist would be allowed to employ dentists for up to one year to provide services to patients until the practice can be sold.

An issue related to ownership is the employment of dentists. In 1996, Alabama introduced a bill to permit dentists to be employed by hospitals. A similar provision was dropped from a Colorado bill.

Health System Reform/Universal Health Insurance: The disastrous experience of the Clinton administration in promoting universal health insurance coverage in the first few months in office had a trickle-down effect. Not a single state came close to enacting anything remotely resembling a universal health system in 1995 or 1996. In fact, ambitious reforms in states such as Minnesota and Oregon were scaled back.

But there are exceptions. In Massachusetts, draft proposals have been circulated this year calling for a health care minimum wage bill, which would require employers to pay half the cost of health care coverage for full-time workers. The proposal faces strong opposition from the business community.

Governor Howard Dean of Vermont, an advocate of universal health care, touted the real strides made in his state on health care reform by guaranteed coverage for all children under the age of 18 and low-cost insurance availability under the Health Access program.

While universal plans generated little enthusiasm, several states did pass incremental insurance reforms, limiting the ability of insurers to restrict coverage for preexisting conditions, allowing for portability of coverage and permitting voluntary purchasing pools.

Medicaid: During 1995, Illinois witnessed the loss of adult dental services under Medicaid, but Wisconsin enjoyed success in raising the fees for providing children's dental services to 75% of the statewide average. Oklahoma received a waiver to expand its statewide managed care system under SoonerCare. In California, a U.S. magistrate approved a revised fee schedule for California's Medicaid program, Denti-Cal. The change reduced program costs by about $180 million, accomplished by reducing fees for as many as 56 procedures. California also changed Medi-Cal to require patients to indicate in writing their choice of provider or plan, and revised procedures for reimbursing providers. Texas requires MCOs enrolling Medicaid patients to provide them with written information about the operation of the program and its providers.

About a dozen states have received Medicaid waivers from the Health Care Financing Administration to implement statewide five-year pilot projects (Section 1115 waivers). The waivers allow states to expand the eligible population for Medicaid services. This has prompted a number of states to experiment with large-scale managed care delivery systems for their Medicaid populations.

Other states applied for and received more limited local waivers, called freedom-of-choice (Section 1915(b)) waivers. These waivers are initially granted for a two-year period and apply only to traditional Medicaid populations.

Division of Science

Council on Scientific Affairs

American Dental Association
Health Foundation

ADA Health Foundation
Research Institute

ADA Health Foundation
Paffenbarger Research Center
at the National Institute of
Standards and Technology

Notes

Council on Scientific Affairs

Slagle, William F., Tennessee, 1996, chairman
Ahlstrom, Robert H., Nevada, 1996
Armitage, Gary C., California, 1999
Austin, B. Peter, Wisconsin, 1997, *ad interim*
Boghosian, Alan A., Illinois, 1996
Byrne, B. Ellen, Virginia, 1998
Chan, Jarvis T., Texas, 1999
Ciancio, Sebastian G., New York, 1998
Glick, Michael, Pennsylvania, 1999
Greer, Robert O., Colorado, 1999
Kyger, Billie Sue, Ohio, 1996
Löe, Harald, Connecticut, 1994 Gold Medal Award recipient
Pallasch, Thomas J., California, 1997
Rothwell, Bruce R., Washington, 1998
Schallhorn, Robert G., Colorado, 1998
Suzuki, Jon B., Pennsylvania, 1997
Vigna, Edward, Nebraska, 1997
Burrell, Kenneth H., senior director
Shearer, Brian G., director, Information and Policy
Whall, Clifford W., Jr., director, Evaluations
Wozniak, Wayne T., director, Evaluations Criteria

Meetings: The Council on Scientific Affairs met on June 7-8, 1995; September 28-29, 1995; and February 13-15, 1996. Future meetings will be held June 11-13, 1996 and September 18-20, 1996. A supplemental report will be filed after completion of these meetings.

Scientific Research and Evaluation

Many of the Council's recent activities support Objective 8 of the Strategic Plan, which directs the Association to effect sound research on issues that notably influence the oral health of the public, the practice of dentistry and the well-being of the dental team. In order to realize its objectives, the Council has continued to refine the Association's Research Agenda, which is reviewed and amended yearly to identify important research priorities for itself, government agencies and allied organizations.

As part of its duties described in the *Bylaws* and Objective 8 of the Strategic Plan, the Council developed and adopted a document on research issues of importance to the practice of dentistry. It identifies the role of the American Dental Association as a facilitator for the national dental research effort, including promotion of adequate research funding for research training and technology transfer programs conducted by the ADA Health Foundation (ADAHF), the National Institute of Dental Research (NIDR), the Agency for Health Care Policy and Research and other national foundations and institutions which support or conduct research related to the oral health sciences.

In fulfilling this function, the Association works closely with the American and International Associations for Dental Research (AADR, IADR), the American Association of Dental Schools (AADS), professional specialty groups, government agencies and industry.

The Association maintains scientific expertise on its staff and in the Research Institute (RI) to conduct, evaluate and anticipate new research of importance to the practitioner; to test new methodologies, develop standards and establish guidelines for acceptance of various dental products; and to address other critical issues. The RI and the Paffenbarger Research Center serve as models of effective public and private collaboration and should continue their research into technologies and materials of greatest benefit to the public and the profession. As needed, other research should be carried out through extramural contractual arrangements.

The Council believes that some of the most vital roles and important responsibilities of the Association are in the area of knowledge and technology transfer, and in assuring that the profession is continuously kept abreast of scientific and technological advancements. It also believes the quality of the Association's scientific sessions should be enhanced to promote practice procedures consistent with the advancing frontiers of the oral health sciences.

The Council thus reviewed issues of patient and provider safety, including governmental alerts and ethical/legal topics; health services research, including social behavioral issues; and treatment-oriented research of immediate and emerging importance in the management of oral diseases. The Council believes that these are the issues which have short- and long-term impact on the quality of patient care and the continuing development of dental practice.

The Council believes that the list of research issues is not exhaustive and should be reviewed and modified periodically. Following are several areas of research that need to be addressed.

Issues of Infection Control and Patient and Provider Safety.

- Infection control and patient and provider safety against airborne and bloodborne pathogens

- Chemical collection devices and other aspects of waste management in dental practice
- Waterlines in dental equipment and quality of water in coolant and irrigant systems

Issues of Health Services Research.

- Prevention activities in dental practice
- Various oral health care delivery systems
- Barriers to oral health care and strategies for extending quality care to all Americans
- Effect of managed care and cost on practicing, academic and public health dentistry, and its ultimate effect on oral health of the American people

Issues in Research on Management of Oral Diseases.

- Management of oral diseases such as effective mercury-free biocompatible dental materials for posterior restorations
- The infectious nature of caries and periodontal disease and development of appropriate individual patient risk-based assessments for their treatment and prevention
- The mechanisms of action of fluorides and the total fluoride exposure for reevaluation of optimal fluoride levels in various prevention protocols

Issues of Science Transfer.

- The concept that caries is an infection and should be managed as such
- Collaboration with NIDR on a plan to hold a "Frontiers in Science" program at the Association annual meetings in order to communicate the latest science to the practitioner

Upon completion by the Council, the Research Agenda was presented to the Board of Trustees and adopted (*Trans.*1995:585, 591).

Response to Assignment from the 1992 House of Delegates

Ethical Treatment and Referral of HIV-Positive/AIDS Patients: Resolution 92H-1992 (*Trans.*1992:650) directed appropriate agencies of the Association to develop guidelines to assist the dentist in the interpretation of laboratory test results associated with HIV infection and to relate the significance of these laboratory values to the performance of specific dental procedures. The Council and the Division of Legal Affairs prepared a monograph entitled "Dental Management of the HIV-Infected Patient." The monograph was sent to members as a supplement to the December 1995 issue of *The Journal of the American Dental Association.*

Response to Assignment from the 1993 House of Delegates

Uniform Labeling of Local Anesthetic Cartridges: Resolution 31H-1993(*Trans.*1993:716) directed the Association, in cooperation with local anesthetic manufacturers, to pursue the development and implementation of a uniform system of color-coding for local anesthetic cartridges that identifies the type and concentration of local anesthetics and vasoconstrictors. In addition, the label should have a legible print size and print that is durable enough so that it will not be removed by normal office handling.

Industry representatives met with members of the Association and the Accredited Standards Committee MD156 Working Group on Cartridges, Needles and Syringes. A proposed color-coding system was developed and circulated for comment. The final color-coding system will be completed in the autumn of 1996.

Response to Assignment from the 1994 House of Delegates

Model Material Safety Data Sheet Form: Resolution 21H-1994 (*Trans.*1994:676) directed the Association to develop a model material safety data sheet (MSDS) form for products containing chemicals used in the dental office. The resolution further directed that the model MSDS form be submitted to OSHA for review and comment and that all manufacturers be encouraged to adopt the form.

A draft model MSDS format was developed and discussed with the dental industry. The Association is also working with the National Advisory Committee on Occupational Safety and Health (NACOSH) regarding the Hazard Communication Standard. The dental industry is also undertaking activities with OSHA and NACOSH to seek extensive reduction in the MSDS requirement. Submission of the model MSDS format to OSHA for review and comment will be made at a suitable time commensurate with these activities. The Council has been working closely with the Washington Office on this issue.

Other Council Activities

Backflow Prevention and the Dental Office: The Council has become aware that local regulatory authorities are increasingly requiring dentists to install testable backflow prevention devices in their offices. The Council was unable to determine the scientific justification for such a requirement. A fact-finding meeting was held with representatives from the Centers for Disease Control and Prevention (CDC), the President of the American Backflow Prevention Association (ABPA), and local water and plumbing regulators from the Atlanta area.

The primary concerns of local regulators centered on the supposed need to protect cross-connected water systems from potential aspiration of oral fluids through the high-speed handpiece, air/water syringe and cuspidor. Such aspiration, which was hypothesized to occur during a sudden drop in water pressure (e.g., during a water main break), has apparently raised concerns about bloodborne diseases being transmitted via water systems cross-connected to the dental unit.

Subsequent to this fact-finding meeting, representatives from the Association and CDC were invited to make presentations at the annual meeting of the ABPA (April 29-May 1, 1996). In preparation for this meeting, the Council and the Association's Board of Trustees adopted a statement on backflow prevention and the dental office. The statement,

which was distributed to participants at the ABPA's annual meeting, primarily addressed the near-zero risk of bloodborne disease being transmitted as a result of backflow from the dental unit. The CDC published a similar statement in June 1996.

The presentations made by the Association and CDC at the ABPA meeting were well-received. The ABPA is currently developing policy on this issue; a statement is expected during the summer of 1996.

Dental Unit Waterlines: In view of the large body of scientific literature demonstrating biofilm formation in dental unit waterlines, the Council convened an expert panel to address the issue. The panel consisted of practicing dentists currently serving on the Council, as well as representatives from the CDC, the Food and Drug Administration, the NIDR and academia. The American Dental Trade Association and the Dental Manufacturers of America also sent liaisons to the meeting to represent the dental industry. The panel met on August 30-31, 1995 at Association headquarters.

The panel reviewed the scientific literature and found clear evidence that dental unit waterlines are commonly contaminated by opportunistic microbial pathogens and that water delivered to patients during dental care is often below the microbiological standard for drinking water. The panel developed a statement on dental unit waterlines which was subsequently adopted by the Council and the Association's Board of Trustees (*Trans.*1995:585, 590).

The statement set an ambitious and aggressive course to encourage industry and the research community to improve the design of dental equipment. The statement went on to set a goal for the profession so that, by the year 2000, water delivered to patients during nonsurgical dental procedures should contain no more than 200 colony-forming units per milliliter (cfu/ml) of aerobic mesophilic heterotrophic bacteria at any point in time in the unfiltered output of the dental unit.

The Council has also been working to inform the profession on issues relating to biofilm and dental unit waterlines. An article reviewing the subject and offering interim recommendations to the profession was published in the February 1996 issue of *The Journal of the American Dental Association.*

Standardization Activities: The Council acts as Administrative Sponsor and Secretariat of the only national voluntary standards program in dentistry.

Accredited Standards Committee MD156 (ASC MD156). ASC MD156 met in San Francisco on March 12, 1996. New work proposals for endodontic posts and orthodontic brackets and buccal tubes were added to the work program, which currently has over 93 projects registered with the American National Standards Institute (ANSI). The Council approved four general Acceptance Program guidelines which incorporate all the ANSI/ADA specifications produced under the work groups of the ASC MD156. These were guidelines for restorative materials, prosthodontic materials, instruments and equipment. Revised guidelines for manual and powered toothbrushes were also adopted by the Council.

International Organization for Standardization/Technical Committee 106 (ISO/TC106). The Association, through the Council, sponsors participation of the United States in ISO/TC106, Dentistry, as Secretariat of the U.S. Technical Advisory Groups (US TAGs). The US TAGs are responsible for recommending the U.S. vote on all international dental standards. The US TAGs are also responsible for determining the U.S. position on the development of international standards. Membership on the TAGs includes the profession, industry, academia and government. The trend towards the global harmonization of standards will demand that all dental products comply with the requirements of these international standards in the future. This assures the availability of high quality dental products for use by dentists in the United States.

Actions taken by ISO/TC106 resulted in casting the U.S. vote for 20 Draft International Standards, 13 Committee Drafts, eight new work items, and reaffirmation of four International Standards. Over 35 delegates from the United States attended the meeting of ISO/TC106 in Kyoto, Japan from October 30-November 4, 1995.

Dental Students Conference on Research: The 1996 Dental Students Conference on Research took place March 30-April 2 at the University of Texas Health Science Center—San Antonio, Dental School. Dental students from 59 schools in the United States and Canada participated in this year's meeting. The keynote address was presented by Dr. Harold C. Slavkin, director, National Institute of Dental Research. Presentations included talks on Creativity and Scientific Research and Evidence-Based Clinical Decision Making. Conference attendees were also invited to take part in UTHSC's Annual Dental Science Symposium.

1995 Health Screening Program: Over 1,700 U.S. and foreign dentists who were registered for the 1995 annual session participated in the Health Screening Program.

Dentists were offered the following screening tests: blood pressure and weight; head, neck and oral examination; hepatitis B; human immunodeficiency virus (as in the past seven years, HIV testing was anonymous and the summary results were announced in the *ADA News*); urinary mercury analysis; periodontal screening and recording; podiatry; resting electrocardiogram; SMA 23 blood chemistry, including high- and low-density lipoproteins; latex hypersensitivity; and carpal tunnel syndrome evaluation.

As in past years, in order to broaden the database to include the entire dental team, dental hygienists and dental assistants were also invited to participate in the hepatitis B, HIV and latex hypersensitivity screening portions of this year's program. Close to 250 hygienists and assistants participated.

Corporate support, as well as contributions for equipment, materials and services, for this year's program was coordinated through the Health Foundation. Volunteer support to the staff of the Health Screening Program was provided by the Dental Hygiene Program of the Community College of Southern Nevada. Staffing for the head, neck and oral examination screening was coordinated through the Department of Veterans Affairs.

The number of individuals participating in the Health Screening Program has increased each year. New tests, such as latex hypersensitivity and carpal tunnel syndrome, were added to obtain data relevant to emerging issues.

Resolutions: This report is informational in nature and no resolutions are presented.

American Dental Association Health Foundation

Gaines, James H., South Carolina, 1996, president
Anderton, Robert M., Texas, 1999, (ADA Board member)
Austin, G. Ken, Oregon, 1999, (outside director)
Crawford, Robert D., Ohio, 1997, (outside director)
Finagin, William B., Maryland, 1997, (ADA Board member)
Maggio, Frank A., Illinois, 1998, (ADA Board member)
Meskin, Lawrence H., Colorado, 1996, (outside director)
Tarrson, E. "Bud", Illinois, 1998, (outside director)
Till, Michael J., Minnesota, 1996, (ADA Board member)
Volpe, Anthony R., New Jersey, 1996, (outside director)
Zapp, John S., secretary
Czarnecki, Robert N., director, administration
Edwards, Dwight S., director, development
Nelligan, Raymond J., controller

Meetings: The ADA Health Foundation Board of Directors met in the Headquarters Building, Chicago, on August 2, 1995 and February 22, 1996. These meetings were held in conjunction with sessions of the Board of Trustees of the American Dental Association.

Personnel: The 1996 annual session will mark the retirement of Dr. Michael J. Till and Dr. Anthony R. Volpe as Foundation Directors. The Foundation wishes to express its appreciation to Dr. Till and Dr. Volpe for their efforts and thoughtful insights during this formative period in the Foundation's expansion. Their knowledge in dental practice, education and business contributed greatly in the development of the Foundation's revised mission.

The Strategic Plan of the American Dental Association: The Health Foundation provides administrative and financial assistance to the Paffenbarger Research Center (PRC) in Maryland and the Research Institute (RI) in Chicago. Through the Foundation, effective sound research on issues that significantly impact the oral health of the public, the health of the dental team and the practice of dentistry is realized. The Foundation's management of the trusts, endowments and extramural programs within its purview demonstrates its support for a variety of worthwhile programs. Programs in public dental education, infection control and other educational conferences, Seal promotion, health screening and access activities demonstrate the Foundation's commitment to its goals and objectives. In sustaining its activities and programs, the profession, through the Foundation, demonstrates its belief in the overall goals and objectives of the Association's Strategic Plan.

Foundation Development Activities: Aware of the need to inform all segments of the dental community and dental industry of its revised mission, the Foundation conducted several mailings and participated in numerous liaison sessions. Officers of the Foundation and Association presented informational updates on the activities and goals of the Health Foundation at national and regional meetings conducted by dental-related organizations.

Informational mailings directed to volunteer dental practitioners participating at all levels of the Association's governance structure presented the programs and activities of the Foundation. By providing practitioners the opportunity to participate in the Foundation's programs, the mailing resulted in additional direction and support for the Foundation.

During its August 1995 meeting, the Board considered two presentations by outside consulting firms outlining a Prospect Identification Study to be conducted on behalf of the Foundation. Upon consideration, the Board approved the study presented by Grenzebach Glier and Associates. By identifying a "core group" of individuals rated according to their philanthropic potential, the study will enable the Foundation to focus its "gift giving" activities on the 40,000 members identified by the study.

Additional developmental activities considered by the Board of Directors included corporate and industry solicitation, special events, a Capital Campaign Feasibility Study and the Corporate Match Program. In 1995, organized dentistry's contributions of $100,000 were matched by ten Foundation corporate partners. Continuation of this program was approved by the Board of Directors.

Office of Management and Budget Compliance Audit: In accordance with the Office of Management and Budget (OMB) Circular A-133, *Audits of Institutions of Higher Education and Other Nonprofit Institutions*, Grant Thornton performed an audit of the ADA Health Foundation federal assistance program for the year ending December 31, 1994. This Circular requires an annual independent audit addressing financial, internal control and compliance matters. Concerning compliance with specific requirements, the auditor's opinion stated that the Foundation complied, in all material respects, with the requirements governing types of services allowed or not allowed; eligibility, matching, level of effort, or earmarking; reporting; cost allocation; special requirements; claims for advances and reimbursements; and amounts claimed or used for matching that are applicable to its major federal program.

The auditor's report and recommendations were presented to the Audit Committee of the ADA Board of Trustees in August 1995. No significant questions were revealed in the report.

Norton M. Ross Award: Established in 1990, the Norton M. Ross Award for Excellence in Clinical Research acknowledges outstanding accomplishments in clinical investigation that have significantly contributed to the prevention of oral diseases. The Foundation Board of Directors, based on a six-member selection committee

recommendation, named Dr. Robert Gorlin as the 1995 award recipient. The $5,000 award was funded by the ADA Health Foundation with a grant provided by the Warner-Lambert Company.

Frederick McKay Award: In 1995, the Foundation's Board of Directors took action initiating an award for outstanding achievement in the area of preventive dentistry. The Frederick McKay Award for Excellence in Preventive Dentistry was inaugurated during the 1995 Annual Session of the American Dental Association. Dr. Larry Coffee was named as the 1995 award recipient. The $5,000 award was funded by the ADA Health Foundation as a result of a grant provided by Accutron Incorporated.

Foundation Support Requests/Grants: At its August 1995 and February 1996 meetings, the Board of Directors of the Health Foundation considered numerous requests for financial support for scientific research, education and access-related projects. These grant requests reflected a wide range of activities, all designed to enhance the quality of care provided by the profession. Projects submitted to the Foundation for consideration were reviewed at several levels: to assure compliance with the 501(c)(3) charter of the Foundation, to determine the scientific significance and care delivery potential of a proposed research project and to determine the general merit of the project. The Foundation's Grant Administration Committee reviewed each proposal prior to final action by the Board of Directors.

Scientific Research Projects. The Foundation Board reviewed several requests for financial support of worthy research programs. The Board determined that a lidocaine study, a study of biofilms in dental waterlines and an ergonomic research project would be supported by the Foundation. The Board also approved a grant supporting a Synthesis of Ammonium Salt project.

In addition to awarding financial support for these projects, the Board has initiated discussions leading toward the development of Request for Proposals (RFPs) for research studies in the areas of wastewater management and biofilms in dental waterlines. Once completed and appropriately reviewed, these RFPs will be distributed for the solicitation of specific research proposals.

Dental Education. During its August 1995 meeting, the Board of Directors approved the Foundation's active solicitation of funds in support of the Minority Scholarship program conducted by the ADA Endowment and Assistance Fund. The Board also determined that discussions should be initiated to further define the relationship between the two agencies in support of dental education.

In addition, the Foundation Board approved support for the National Strategic Conference for the Prevention and Control of Pharyngeal and Oral Cancers, as well as the Second National Conference on Dentistry's Role in Preventing Child Abuse and Neglect.

Access-Related Programs. The Foundation's Board of Directors considered numerous requests for financial assistance submitted by access programs and awarded support to the National Foundation of Dentistry for the Handicapped and the Special Athletes, Special Smiles programs.

Research Fellowships/Awards:

American Association for Dental Research (AADR). The Foundation Board of Directors approved funding for three research fellowships sponsored in conjunction with the AADR. Each research fellow is provided $3,000 which includes a stipend, supplies and travel funds so that the recipient may present research results at the annual AADR meeting.

Young Investigator Award. As a requirement of the Specialized Materials Science Research Grant from the National Institute of Dental Research, the Paffenbarger Research Center annually appoints two young investigators to the industrial scholars program. The program, begun in 1940, brings industrial and dental research together in an environment outside the dental school. This program is supported by the ADA Health Foundation, with an educational grant provided by the Colgate-Palmolive Company.

Research Training Fellowship. Recently initiated, the Research Training Fellowship program is conducted at the Foundation's Paffenbarger Research Center (PRC). The program includes a full-time fellow working in conjunction with the scientific research staff of the PRC. Funding for this program is supported through a $30,000 education grant provided to the Foundation by Great-West Life & Annuity Insurance Company.

New Dentist Scientist Award. The Foundation Board of Directors initiated the New Dentist Scientist Award in 1995. The award is designed for dentists who have completed the National Institute of Dental Research (NIDR) dentist scientist program. Candidates must have completed the NIDR program within the past three years and have not received grant funding. Three individuals were identified as award recipients in 1995. In addition to the $5,000 awarded by the Foundation, each recipient was provided a $5,000 matching award from the researchers' institution.

Sponsored Programs and Activities: The Foundation annually receives awards from federal and corporate sponsors to carry out research, educational and other supporting projects. The schedule on the following tables indicates that for the year ending December 31, 1995, $3,011,554 was expended for sponsored purposes. The major areas of expenses were: federal government funded research totaling $1,779,990; corporate sponsored research amounting to $618,253; and corporate support for various extramural programs totaling $475,013.

Resolutions: This report is informational in nature and no resolutions are presented.

American Dental Association Health Foundation
Federal Government and Corporate Sponsored Activity
For The Year Ended December 31, 1995

Table 1: Federal Government Sponsored Research Program

Granting Agency/Research Project Title	ADAHF Project Number	Expenditures[1]
NATIONAL INSTITUTE OF DENTAL RESEARCH:		
Crystal Chemistry of Calcium Phosphates	5-20-10-09	$ 99,745
Prevention of Dental Caries	5-20-20-34	63,892
	5-20-20-42	157,445
Phosphate Activity in Biological Fluids	5-20-20-37	9,984
	5-20-20-41	90,715
Fluoride Effects on Plaque Cariogenic Potential	5-20-20-39	126,880
	5-20-20-45	67,539
Improvement of Preventive and Restorative Materials	5-20-25-15	91,885
	5-20-25-16	89,127
Center of Excellence for Materials Science Research	5-30-00-06	524,779
	5-30-00-07	68,688
Improved Dental Instruments and Materials Through Standard Development	5-15-15-08	155,360
		1,546,039
NATIONAL HEART, LUNG AND BLOOD INSTITUTE:		
Calcification in the Cardiovascular System	5-20-20-32	23,096
	5-20-20-43	183,771
		206,867
FOOD AND DRUG ADMINISTRATION:		
Characterize Tri-Calcium Phosphate Standard Reference Material	5-20-20-35	(4,788)
Develop and Characterize Hydroxyapatite Standard Reference Material	5-20-20-38	303
Characterize Tri-Calcium Phosphate Standard Reference Material	5-20-20-46	4,076
		(409)
NATIONAL CENTER FOR RESEARCH RESOURCES:		
Minority High School Student Research Apprentice Program	5-10-00-13	2,730
		2,730
Total Federal Awards and Expenditures—U.S. Department of Health and Human Services		1,755,227
U.S. DEPARTMENT OF COMMERCE:		
Development, Preparation and Characterization of the Calcium Phosphate SRM	5-20-20-36	36
	5-20-20-40	24,250
	5-20-20-44	477
		24,763
TOTAL FEDERAL SPONSORED RESEARCH ACTIVITY		**$1,779,990[2]**

Table 2: Extramural Programs

Program Title	ADAHF Project Number	Expenditures[1]
Infection Education Programs	7-15-25-03	$ 120,263
Special Projects in Drugs and Therapeutics	7-15-30-01	79,595
Monograph Series	7-15-30-06	40,000
Chemistry Conference	7-15-30-08	3,172
Conference on HIV Issues	7-15-35-08	59,696
Dental Student Research Conference	7-15-35-09	318
Norton M. Ross Memorial Lectures	7-10-00-18	2,400
American Dental Association Seal of Approval Promotion	7-15-10-01	46,885
ISO Technical Advisory Group	7-15-15-09	1,463
Hillenbrand Rare Book Fund	7-15-50-01	15
Annual Session Health Screening Program	7-15-55-02	92,539
Corporate Film Support	7-15-60-02	11
Student Appointment Book	7-15-75-02	28,654
Speakers Bureau	7-15-35-05	2
Subtotal Extramural Programs		**$ 475,013**

Table 3: ADAHF Awards Programs

Program Title	ADAHF Project Number	Expenditures[1]
Gold Medal Award	7-15-35-01	$ 9
Sarner Award	7-15-40-01	1,000
Norton M. Ross Award	7-15-35-07	11,474
National Museum of Dentistry	7-05-00-01	50,000
Frederick McKay Award	7-05-05-06	5,000
Subtotal ADAHF Awards Programs		**$ 67,483**

Table 4: Corporate Sponsored Programs

Project/Activity Title	ADAHF Project Number	Expenditures[1]
GENERAL RESEARCH:		
Research-Unrestricted	2760	$ 5,000
		5,000
PATENT ROYALTIES:		
Dentin Bonding	7-20-25-03	281,677
Calcium Phosphate Cements	7-20-20-08	26,039
Glass Ceramic Inserts	7-20-25-05	5,083
ACP SmithKline	7-20-20-09	24,835
Staff Transition Funds	7-05-05-04	58,180
Paffenbarger Research Center Equipment Purchases	7-05-05-05	3,248
		399,062
RESEARCH INSTITUTE:		
Biofilm Dental Unit Waterline Study	7-05-05-07	23,750
Free Fluoride vs. MFP	7-10-00-20	38,789
Chemistry Program Research	7-10-00-21	3,963
Nitrous Oxide Seminar	7-10-00-25	9,301
Lidocaine Study	7-10-00-26	8,341
		84,144

Table 4: Corporate Sponsored Programs (continued)

Project/Activity Title	ADAHF Project Number	Expenditures[1]
PAFFENBARGER RESEARCH CENTER:		
Micro Equipment Fabrication	7-20-20-07	2,235
Acid Calcium Phosphate Fluoride Treatment	7-20-20-11	43,925
Liebinger CPC Project	7-20-20-12	32,318
Lifersavers Toothpaste Study	7-20-20-13	15,231
Young Investigators Award	7-20-20-14	12,368
SmithKline Beecham Research and Development Plan	7-20-20-15	1,141
NMR Facility	7-20-25-04	22,829
		130,047
Subtotal Research		**$ 618,253**

Table 5: Education, Access, Trusts, Endowments and Other Programs

Program Title	ADAHF Project Number	Expenditures[1]
EDUCATION:		
Student Scholarship Program	7-05-05-01	$ 15,000
		15,000
ACCESS:		
National Foundation of Dentistry for the Handicapped	2766	1,200
		1,200
TRUSTS AND ENDOWMENTS:		
Bartfield Bequest (New Dentist Scientist Awards)	2746	10,000
		10,000
OTHER:		
Prior Year Balance	2740	37,821
Unrestricted Contributions	2743	5,021
Special Events	7-05-05-02	1,773
		44,615
Subtotal Education, Access, Trusts, Endowments and Other Programs		**$ 70,815**
TOTAL CORPORATE SPONSORED ACTIVITY (Tables 2-5)		**$ 1,231,564**
TOTAL SPONSORED ACTIVITY		**$ 3,011,554**

[1] Includes purchases of capital equipment.

[2] Federal Sponsored Research Activity comprises direct costs of $1,086,977 and indirect costs of $693,013. The recovered indirect costs are reimbursed to the American Dental Association for financial and administrative services received.

ADA Health Foundation Research Institute

Fan, P. L., senior director
Mueller, Herbert, director, Materials Science Department
Naleway, Conrad A., director, Chemistry Department
Siew, Chakwan, director, Toxicology Department

Role of Research Institute: The Research Institute conducts scientific studies to address critical issues facing practicing dentists and to assist in the development of national and international standards. It also conducts product evaluations that are used by the Council on Scientific Affairs in its Seal of Acceptance Program. The activities of the Research Institute relate to Objective 8: Research, of the Strategic Plan of the Association.

Materials Science Department

Biomaterials Department: Research activities of the Biomaterials Department are supported by a contract (which is in its last year) from the National Institute of Dental Research. In addition to testing products for compliance with ANSI/ADA standards, the Department also conducted research in the following areas: porcelain fused to metal (PFM) systems; metal-protein interactions; direct vs. indirect cured composite resins; silica in investment materials; hybrid ionomers; dentin etching and wettability; and breakage of dental hand instruments.

Chemistry Department

Urinary Mercury in Member Dentists: "Spot" urine samples were used to determine occupational mercury exposure among practicing dentists. Urinary mercury specimens, collected from 1,395 practicing dentists attending the American Dental Association's 1995 Health Screening Program (HSP) in Las Vegas, were analyzed on site to provide immediate results. The overall mean value of mercury was 5.9 ug/L (median of 4.2 ug/L), which is slightly elevated from the lowest mean value (4.8 ug/L) observed in the 1994 HSP. These recent averages are slightly greater than those found in the unexposed general population (1.0-3.0 ug/L) but are considerably lower than five years earlier. The mean mercury level for dentists in 1990 was 8.1 ug/L, and 15 years ago (1980) it was 18.2 ug/L. These results suggest greater compliance with the Association's recommendations for improving mercury hygiene. Dentists with high urinary mercury concentrations were offered the opportunity to consult with staff members at the HSP concerning their mercury hygiene practices.

Of the participating dentists, 184 (13.2%) were found to have mercury levels above 10 ug/L, with 38 dentists (2.7%) above 20 ug/L and seven dentists with levels above 50 ug/L. In addition, 70 dentists, including some with mercury levels 20 ug/L or above and some with nondetectable urinary mercury, were screened for potential changes in neurobehavioral performance. Earlier results from the same long-term study (published in 1995) had identified minor subclinical changes between the high-exposure and low-exposure populations, but the level at which those changes occur is unknown. Those dentists with levels above 20 ug/L were invited to submit urine specimens after returning to their offices in order to verify their exposure levels and to assist them in reducing their exposure.

Results from these mercury screening programs have been utilized in the submission of a National Institutes of Health grant application to assess the potential health effect of clinical and occupational exposure to mercury within the dental profession. This study should help to define the level at which occupational mercury exposure may produce subclinical, possibly reversible, changes in nephrological and neurobehavioral function.

Fluoride Research: A new analytical method was developed in collaboration with industry to better quantify the bioavailable concentration of fluoride within commercial dentifrices. In addition, a procedure is being developed to assess the potential effect of various additives in several dentifrices which may alter the bioavailability of the fluoride agent. This method uses a more comprehensive digestion procedure and is applicable to most currently marketed fluoride-containing dentifrices irrespective of their abrasive system. This new method was incorporated in a collaborative study with the University of Michigan to examine the levels of fluoride in dentifrices marketed in different countries. The results illustrated the clear superiority of U.S.-marketed dentifrices. The analytical method for total fluoride was adopted for the International Organization for Standardization (ISO) standard for fluoride toothpastes.

Product Testing: The Chemistry Department continues to test and help evaluate scientific data on therapeutic products submitted to the Council on Scientific Affairs for the Seal of Acceptance. Special attention is given to reviewing marketed fluoride-containing rinses, gels and dentifrices. New laboratory procedures and analytical methodology are continually developed to evaluate the potential effects of new additives to dental products such as dentifrices.

Amalgam and Mercury in Dental Wastewater: As a consequence of growing concern about the potential environmental effects of amalgam particulate generated in dental offices, the Chemistry Department has undertaken a detailed study to analyze clinical wastewater samples as well as in vitro amalgam/enamel ground samples. These studies examined the physiochemical and chemical properties of wastewater and the potential efficacy of commercially available amalgam separators. Studies were done in collaboration with the Naval Dental Research Institute at Great Lakes, Illinois. Because of the high density and the relatively large size of amalgam particulate, most of the amalgam particulate will easily settle-out of the solution. Samples collected directly at chairside suggested that approximately 10% of amalgam particulate is made up of

particles less than ten microns in size. Samples collected further downstream, at the street outlet, indicated that more than 50% of particles were less than ten microns in size. Furthermore, a small but significant fraction (<1 to 10%) of amalgam is less than 0.45 microns when collected at either chairside or at the street outlet. Particles smaller than 0.45 microns are considered soluble by the EPA.

Preliminary studies have been undertaken to develop possible methods to treat colloidal amalgam and soluble mercury, which are not removed with currently available commercial amalgam separators.

The Chemistry Department is also involved in evaluating a proposed ISO laboratory test method to assess the efficiency of amalgam separators. An international discussion regarding the particulate size distribution of "typical" dental waste has resulted in the Chemistry Department laboratory undertaking a critical analysis of samples and analytical methods utilized in other international research laboratories.

Mechanism of Action of Fluoride Agents in Caries Inhibition: The Chemistry Department has continued to work closely with the Paffenbarger Research Center to assess the effects of ambient versus enamel-bound fluoride on reducing enamel decalcification. This research assesses a potentially more effective mechanism to deliver fluoride into the enamel-mineral structure and the potential development of products that would incorporate more fluoride at lower topical fluoride concentrations into enamel, thus making the enamel more resistant to decalcification.

A second study, supported by industry, compared the cariostatic effects and potential differences in mechanisms of action of the monoflurophosphate ion and free fluoride ion.

Toxicology Department

Infectious Hazards: Dentists, as well as dental hygienists and chairside assistants, were offered serum testing for various markers of hepatitis B virus (HBV) and human immunodeficiency virus (HIV) through the Health Screening Program (HSP). Based on the HSP results, dentists receiving one or more inoculations of hepatitis B (HB) vaccine accounted for 87.9% of U.S. practitioners and 77.2% of foreign practitioners. Almost 91% of dental hygienists and chairside assistants were immunized with an HB vaccine. These data continue to show that dental professionals have one of the highest acceptance rates of HB vaccine of all health care professionals. Such compliance is also reflected in the 8.9% of dentists displaying current or prior infection with HBV. This is about one-half the HBV infection incidence since the availability of the HBV vaccine (15%), but it is still about double the incidence among the U.S. general population (4%). Foreign dentists were considerably higher at 18.9% and hygienists/assistants lower at 5.1% HBV infection incidence. While current infection control recommendations for the prevention of HBV transmission in the dental operatory have been effective in reducing HBV infections, HBV remains one of the highest infection risks for dental professionals.

For the tenth consecutive year, dentists attending the HSP were offered anonymous screening for antibodies to the human immunodeficiency virus (HIV). Of 1,648 U.S. and foreign dentist volunteers, none tested positive for HIV antibodies. Similarly, none out of 206 dental hygienists and assistants tested positive. Since 1987 over 15,000 dental professionals have been tested for HIV infection, with only one dentist without self-identified high risk behaviors for HIV infection showing evidence of HIV infection. These data suggest that the risk of becoming infected with HIV by treating dental patients is less than 0.007%, which is significantly below the 0.25% rate for the general U.S. population. Admittedly, these HSP data may be biased in that individuals who are infected with HIV might choose not to be tested. However, because the HIV screenings conducted during the HSP over the past ten years have been anonymous and concurrent HBV screenings indicated increased risk for HBV infection in the same population, the results generated from these HIV screenings is probably representative of U.S. dental practitioners.

Latex Hypersensitivity: Latex proteins in gloves used for infection control can sensitize an individual to latex rubber, causing a range of allergic reactions from dermatitis to anaphylaxis. It has been thought that the incidence of latex allergy may be increasing among dental professionals. Therefore, in 1994 the HSP offered skin-prick testing (SPT) to assess the incidence of latex hypersensitivity among dentists and to establish a baseline by which future screenings may be measured. In 1994, just under 1,000 dentists were screened for latex reactions and about 5% showed hypersensitivity.

In 1995, slightly more than 700 dentists were screened and the incidence of hypersensitivity rose to about 7%. While it is still premature to conclude that the incidence of latex hypersensitivity is increasing, these data are cause for concern and further investigation. To this end, serum results from the ADA archive of prior-year HSP samples are being analyzed by a new FDA-licensed in vitro latex hypersensitivity test from Diagnostic Products Corporation. This test has the advantage of being able to be performed on serum samples collected at various times by laboratory staff. In contrast, the SPT must be supervised by a physician and requires the physical presence of the patient for up to one hour. Although serum testing is generally considered to be less accurate than the SPT, it has the potential to identify trends in occupationally derived latex hypersensitivity with a larger sample size.

Carpal Tunnel (CTS) and Thoracic Outlet (TOS) Syndromes: CTS and TOS have been diagnosed in individuals performing repetitive tasks involving fine muscle movement. Reliable data has not been available on the incidence of CTS and TOS among dentists. Therefore, for the first time, CTS and TOS screening were offered at the 1995 HSP.

CTS involves compression of the median nerve at the wrist, which may result from repetitive motion/strain during dental procedures. TOS involves compression of several nerves at the base of the neck or upper chest and is often mistaken for CTS. TOS is caused by postural and/or structural conditions aggravated by the elevation of arms or exaggerated movements of the head and neck. The incidence of CTS is estimated at about 1% in the general population and between 10-17% of the industrial workforce. One study of a group of dental hygienists/assistants found a 12% incidence. Estimates for the incidence of TOS are unavailable.

At the 1995 HSP, 136 dentists volunteered to be tested for CTS and TOS. Preliminary results indicated that 28 dentists

(21%) tested positive for CTS and 31 dentists (23%) tested positive for TOS. However, it is not known how much of this percentage was work-related. Therefore, these tests gave only a preliminary indication and not a diagnosis. Although the incidence of compression neuropathy was higher than the expected 12% for the group of dentists tested, several factors may have influenced the outcome, including small sample size, self-selected bias, fluctuation of temperature in the testing environment and the lack of a matched control group. Additional and more refined studies will be undertaken in the next few years to ascertain the extent of potential concern.

Carcinogenicity of Lidocaine: Lidocaine is a widely used local anesthetic in dentistry. It is also commonly used for the treatment of ventricular arrhythmias. A metabolite of lidocaine, 2,6-xylidine (2,6-dimethylaniline), at high doses was found to be carcinogenic in rats (NTP Tech. Report No.278, 1990). The Toxicology Department attempted to determine the blood elimination kinetics of both lidocaine and 2,6-xylidine in patients undergoing periodontal surgery to better understand any carcinogenic potential of lidocaine as used in dentistry. Twenty-five patients were placed into three groups receiving 2% lidocaine with different dilutions of epinephrine. Serial blood samples were taken at different time intervals post-injection. Lidocaine and 2,6-xylidine were extracted from blood samples and assayed by GC/MS with electron impact and a detection limit of 0.2 ng/ul. The researchers were able to conclude that standard infiltration local anesthesia with lidocaine does not produce detectable blood levels of the carcinogen 2,6-xylidine. Therefore, concern about a carcinogenic potential of lidocaine in the presence of a vasoconstrictor in a dental setting appears to be unfounded.

Oxygen Radical Formation in Whitener Agents: Most commercial tooth whitener products contain 10% carbamide peroxide as their active ingredient. Carbamide peroxide breaks down during application to form 3% hydrogen peroxide which in turn liberates oxygen and perhydroxyl radicals. Excessive free oxygen radicals have been associated with many pathological conditions including tumorigenesis. A study was conducted that employed an HPLC technique to trap oxygen radical generation with salicylate to form stable measurable derivatives for quantification. Under the experimental conditions, there was minimal systemic oxygen radical formation after exposure to peroxide-containing tooth whitener agents.

Resolutions: This report is informational in nature and no resolutions are presented.

ADA Health Foundation Paffenbarger Research Center at the National Institute of Standards and Technology

Eichmiller, Frederick C., director
Marjenhoff, William A., director, administration
Bowen, Rafael L., distinguished scientist
Chow, Laurence C., assistant director and chief research scientist, Dental Chemistry
Mathew, Mathai, chief research scientist, Dental Crystallography
Schumacher, Gary E., chief research scientist, Clinical Research
Stephenson, Maurice A. S., chief research scientist, Polymer Chemistry

Role of Paffenbarger Research Center (PRC): The PRC receives funding through the Association's annual grant to the American Dental Association Health Foundation, from National Institutes of Health grants, industrial contracts and grants, and contracts and in-kind contributions from the National Institute of Standards and Technology (NIST). The PRC conducts basic and applied studies in clinical research, dental chemistry, polymer chemistry and dental crystallography. Projects address the dental materials needs of practitioners and are increasingly responsive to the research agenda developed by the ADA Council on Scientific Affairs. Abstracts of PRC research presentations and publications, as well as reprints of published articles and manuscripts presented at Dental Materials Group sessions of the International Association for Dental Research, are available from the PRC by request.

The activities of the PRC, as described in this annual report, relate to Strategic Plan Objective 8: Research. The PRC provides a credible dental research program that has consistently shown that it effects sound research on issues that significantly impact the oral health of the public, the health of the dental team and the practice of dentistry.

Clinical Research: Under the auspices of the NIDR-funded Center of Excellence for Materials Science Research, the development of a metallic direct-filling amalgam alternative is progressing with experimental materials now showing superior transverse rupture shear and toughness properties to dental amalgam. Current studies are aimed at evaluating physical properties, microleakage, condensation instruments, polishing instruments, corrosion and field contamination with the system.

Progress is also being made in a Center of Excellence project designed to develop glass-ceramic restorative materials. PRC-developed inserts that improve the properties of composite restorations were patented by the Foundation and introduced commercially several years ago. Current work is focused on using this microcrystalline ceramic as a high strength filler in conventional composite formulations and for precision-formed crowns, inlays and onlays.

Dental Chemistry: Significant progress has been made recently in a variety of calcium phosphate chemistry research projects at the Paffenbarger Research Center. Under contract from NIST and the Food and Drug Administration, a PRC research team has synthesized and characterized standard reference materials (SRMs) for hydroxyapatite and β-tricalcium phosphate. Staff are currently working to synthesize SRM-quality amorphous tricalcium phosphate and α-tricalcium phosphate.

A PRC research team is conducting contract research for the licensee of the gel, rinse and aerosol applications of the Foundation-patented amorphous calcium phosphate desensitizing and remineralizing technology. The first commercial product, a professional gel, is planned for introduction in early 1997. The licensor of the rights to the gum, dentifrice and confections applications of this technology has announced plans to market a product by late 1997. A clinical trial investigating the remineralization potential of a PRC-developed calcium phosphate-containing chewing gum was recently completed with funding from an industrial contract.

The Foundation received a notice of award that will enable PRC research into the prevention of caries by maintaining grant funding through March 1997. Several new patent applications have been submitted or are in preparation to protect PRC inventions related to improved fluoride treatments. An industrial contract and licensing option have helped fund PRC research related to this technology. This system will allow for effective fluoride treatments at much lower applied dosages. A clinical trial of this technology is currently under way at PRC.

PRC research toward improving fluoride treatments was significantly enhanced by a four-year grant awarded by NIDR to the Foundation for PRC scientists to study fluoride effects on plaque cariogenic potential.

PRC-developed calcium phosphate cements are licensed to an orthopedic fixation company. The company plans to retain the subsidiary to whom the patents were originally licensed as a stand-alone company manufacturing and selling bone cement materials based on this technology. Protocols for studies on periodontal, root socket-filling and implant grouting are under development, and the company plans to begin research on dental applications of this promising material in the near future.

Polymer Chemistry: PRC researchers continue to make significant progress toward improving the Foundation-patented adhesive bonding system. The adhesion patent portfolio is currently licensed to seven dental manufacturers. The Foundation has licensed an adhesion system from NIST that was coinvented by a NIST scientist and PRC research associate; sublicenses have been offered to dental manufacturers.

Progress is also being made in other polymer chemistry projects, including three that are funded by the Center of Excellence grant: the development of polymers for preventive coatings and margin repairs; reducing polymerization shrinkage and stress in resin restorations; and developing novel adhesive cariostatic cements that contain both a calcium phosphate cement and resin phase.

Dental Crystallography: This program continues to be critically involved in characterizing the crystal compositions of components in PRC-developed materials, including glass-ceramics, metallics and calcium phosphates.

Resolutions: This report is informational in nature and no resolutions are presented.

Notes

ADA Holding Company, Inc.

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ADA Holding Company, Inc.

For-Profit Subsidiaries' Annual Report and Financial Affairs

ADA HOLDING COMPANY, INC.
Zapp, John S., chairman, *ex officio**
Uchin, Robert A., president (at-large member dentist)
Johnson, Brian M., chief executive officer and treasurer
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
Ten Pas, William S. (ADA President), *ex officio**
Hunt, Donald S. (outside director)
Klein, H. Raymond (ADA Board member)
Lange, Karl W. (ADA Board member)
Mercer, James F. (ADA Treasurer), *ex officio**
Miller, Jerome (at-large member dentist)
Rahe, John A. (ADA Board member)
Turchi, Lewis J. (ADA Board member)
Yohanan, Robert R. (outside director)

ADA PUBLISHING CO., INC.
Zapp, John S., chairman
Kosden, Laura A., president and publisher
Johnson, Brian M., treasurer, *ex officio**
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
Barry, Victor J., (ADA Board member)
Lange, Karl W. (ADAHC and ADA Board member)
McFadden, Judith (at-large member dentist)
Rose, S. Timothy (ADA Board member)
Schechter, Daniel (outside director)
Stratton, Debra (outside director)
Whiston, David A. (ADA Board member)

ADA FINANCIAL SERVICES CO.
Zapp, John S., chairman, *ex officio**
Murphy, Karen, president and chief executive officer
Johnson, Brian M., treasurer
Sfikas, Peter M., secretary
Thorne, Michele H., assistant secretary
Baker, Robert W., Sr. (at-large member dentist)
Harris, David J. (at-large member dentist)
Hardymon, Stephen A. (outside director)
Hunt, Donald S. (outside director)
Mercer, James F. (ADA Treasurer), *ex officio**
Rahe, John A. (ADAHC and ADA Board member)
Rainwater, Gary (ADA President-elect)
Yohanan, Robert R. (outside director)

ADA Holding Company, Inc.

Introduction: The American Dental Association is the sole shareholder of the Association's for-profit subsidiary, ADA Holding Company, Inc. (ADAHC). ADAHC in turn is the sole shareholder of its two subsidiaries, ADA Publishing Co., Inc. (ADAPCO) and ADA Financial Services Co. (FINCO).

This annual report outlines the business and financial affairs of these two subsidiaries for the year-end 1995 and the first four months of 1996.

Direction and Finance: Incorporated in late 1989, ADAHC began operations on January 1, 1990. The ADAHC Board provides guidance and leadership to its for-profit subsidiaries. The Board consists of eleven directors—four ADA trustees, two at-large member dentists, two outside business directors, the ADA Executive Director as chairman, the ADA President and the ADA Treasurer.

* nonvoting member

In February 1995, ADAHC received $500,000 in dividends from ADAPCO, which it set aside to make a capital contribution to FINCO. In December 1995, ADAHC received an additional $700,000 in dividends from ADAPCO. ADAHC subsequently declared and paid $700,000 in dividends to the ADA.

ADA Publishing Co., Inc.

Introduction: ADAPCO's mission is to produce and distribute, at a profit, credible high-quality publications that inform the dental profession about the latest scientific, socioeconomic and political issues affecting oral health care. Its most important publications are *The Journal of the American Dental Association* (*JADA*), *ADA News* and *Dental Teamwork*.

Business and Financial Operations: For business reasons, in January 1990 the former ADA Division of Editor and Publications was restructured as an independent full-service publishing company, ADAPCO. The ADA entered into an agreement with ADAPCO, transferring its publishing functions to the subsidiary.

The restructuring was remarkably successful. In the first five years of operation, the publishing subsidiary realized increased sales and profits, greater efficiency and economies of scale, while the quality of the publications continued to improve and better meet the needs of the membership. Sales grew 19% between 1990 and 1994, from $7.7 to $9.1 million. In contrast, total expenses before tax increased only 3%, from $7.3 million in 1990 to $7.5 million in 1994. Gross operating income more than tripled during this five-year period from 5% to 17% of sales ($367,000 to $1.6 million); net operating income quadrupled.

Although ADAPCO continues to be successful as a nondues profit center, its financial growth has been affected by changing market trends in the dental field. Industry consolidation and lackluster sales have translated into flat advertising expenditures in 1995 and 1996 (and into declining sales and profits for ADAPCO). In addition, the publishing industry as a whole has suffered from unprecedented increases in paper and postage costs (approximating $700,000 in 1995 for ADAPCO periodicals).

To continue enhancing the quality and financial success of its publications, ADAPCO will be positioned to respond to these changing market trends. The major portion of its sales, approximately 80%, is derived from advertising—one of the most volatile sources of revenue. New publications, new sources of revenue and new avenues to attract industry dollars are being investigated to offset any decline in advertising space sales.

Editorial: ADAPCO has maintained its standing as publisher of dentistry's best-read publications. Independent readership surveys conducted by Perq Research Corp. (Focus) and Healthcare Communications, Inc. (Media-Chek) ranked the *ADA News* as dentistry's best-read publication overall and *JADA* as the best-read dental journal.

In January 1996, ADAPCO entered the second year of its continuing education (CE) program in *JADA*. A cooperative venture with the University of Colorado Dental School, the members-only CE program underwent certain changes this year to make participation more inviting. As a result, participation in the first two months of 1996 was up by about 25% over the same months in 1995. Approximately 4,000 member dentists participated in *JADA*'s CE program in 1995, the program's first year.

ADAPCO also has introduced a number of new features in *JADA* intended to enhance *The Journal*'s value to its readers. Dr. Harold C. Slavkin, director of the National Institute of Dental Research, has begun writing a monthly column on the relationship between research and dental practice. Also, Peter M. Sfikas, ADA general counsel, is writing a monthly column on legal issues pertinent to dentistry.

In the near future, *JADA* plans to introduce a new section called "Clinical Directions," offering brief reports on time-saving tips for clinicians. In addition, *The Journal* is investigating ways to increase student interest and involvement in the publication, working with the ADA Office of Student Affairs.

JADA, in recent months, has presented well-received reports on a wide range of dental topics from updates on infection control requirements to dental office waterline safety to studies on disease prevalence.

The *ADA News* has continued to devote high levels of staff time and energy to the major issues of managed care and marketplace change. Recent coverage has centered on alternatives to managed care, with special emphasis on direct reimbursement.

Like *JADA*, *ADA News* has sought ways to enhance its appeal to students and young dentists. In 1996, the *News* introduced a monthly section called "Starting Out," which focuses on issues and information of interest to dentistry's younger members.

Dental Teamwork's continuing education program entered its third year in 1996 and continues to average more than 500 participants each issue. About 3,400 dental hygienists and assistants participated in the program in 1995.

In recent months, *Dental Teamwork* has offered its readers information on such topics as improving patient relations, exploring educational options and building a stronger dental office team.

In addition to its core publications (*JADA*, *ADA News* and *Dental Teamwork*) ADAPCO also produces the *ADA Washington Report* in cooperation with the ADA Washington Office. Introduced in August 1992 and published 24 times a year, the *ADA Washington Report* provides an insider's view of developments in the nation's capital. This publication also carries news of legislative and regulatory activity at the state level.

ADAPCO regularly provides information for *ADA ONLINE*, the Association's home page on the World Wide Web. Materials include *JADA* abstracts and capsule versions of *ADA News* articles. The company is exploring other Web possibilities.

Also in 1996, ADAPCO began development of a softcover chairside handbook on drugs used in dental care. Accepted Dental Therapeutics is expected to be completed by the early part of 1998.

ADA Financial Services Co.

Introduction: FINCO's annual meeting was held in Chicago on July 28, 1995. The company's Board also conducted business via a telephone meeting on September 25, 1995 and in Chicago on January 22, 1996.

Governance: The FINCO Board comprises eight members and the ADA Treasurer as an *ex officio* member and the ADA Executive Director as chairman and an *ex officio* member. The eight members include two members-at-large; three outside business directors; one ADA trustee from ADAHC; the ADA President-elect; and the chief executive officer.

In April 1996, FINCO's sole shareholder, ADAHC, filled two vacancies with the appointment of two new outside business directors to the FINCO Board. The new directors are Mr. Donald Hunt, retired CEO and President of Harris Bank, Chicago, and Mr. Stephen Hardymon, executive director, Washington State Dental Association.

Financials: FINCO is reporting a net loss for 1995 of $463,945, pre-audit. This loss represents a favorable variance of $103,629 to FINCO's operating budget.

The 1995 start-up monies needed for FINCO to repay disbursements made on its behalf and for future working capital have been obtained through a $500,000 capital contribution from ADAHC and a $305,000 loan from the Association. In addition, Mellon Bank, N.A. has committed to a line of credit with FINCO repayments coming from future ADA 1 PLAN program revenues. Total assets of the company are $304,380 and 1996 operational expenses are projected at $550,000. Profit-sharing in the ADA 1 PLAN through Mellon Bank is projected to begin in the third quarter of 1996.

ADA 1 PLAN Overview/Marketing Strategy: The ADA 1 PLAN was launched in April 1995 as the premiere offering of comprehensive financial services to members of the American Dental Association. The provider of the services under this brand name is Mellon Bank. In one year, the program has grown to include more than 15 product lines serving more than 16,000 participants. Twenty-two state dental societies co-endorse the plan with ADA/FINCO and share in program revenues.

The program's goal is to become the principal provider of financial services to ADA members. The marketing strategy that supports this goal is fourfold:

1. to enhance membership value;
2. to build brand recognition/image;
3. to refine/enhance product offerings; and
4. to increase the numbers of members using more than one ADA 1 PLAN product through cross-selling strategies, e.g., promotional materials for different products are included in credit card billing statements.

In 1996, the objectives are to introduce new products and increase market share through cross-selling while continuing to develop the program's marketing database. Increased advertising and an aggressive trade show strategy are new in 1996. Mini-burst direct marketing is also new this year. This form of direct mail marketing relies on more frequent mailings within an established time frame, but to a smaller number of members each time. Such a tactic allows for better response management in terms of both service to respondents and adjustment to the product offer based on what is learned from each mailing.

ADA 1 PLAN Product Promotions: Key marketing promotions occurring during the first half of 1996 include the following:

Product: Dreyfus Asset Management Account (*New*)
Offer: All-in-one financial management tool. ADA members receive a discount on stock, option and precious metal trades.

Product: Merchant Card Services
Offer: A low discount rate on all card swipe transactions for ADA members.

Product: Home equity/unsecured personal credit line (*New*)
Offer: Special rates for ADA members, plus 1/2% rate discount for members with another ADA 1 PLAN account.

Product: HEAL Consolidation Loan
Offer: A competitive rate and cash rebates for ADA members.

Product: Gold MasterCard
Offer: ADA members and dental team members (*New*) receive offer at low introductory rate for 6 months for purchases *and* balance transfers, interest rebates plus TravelReturns.

Product: Standard MasterCard
Offer: For dental school students with standardized credit limit and no income required to qualify. All other card features the same as GoldCard offer.

Other products being introduced and/or promoted this year through advertising and direct mail campaigns include home mortgages, bank deposit products, education financing, Dreyfus mutual funds and commercial loans. Statement stuffers for all product lines are being included in all credit card billing statements.

Guide to Financial Services: A *Comprehensive Guide to Financial Services* has just been published and is being made available to all members who call about the program. The *Guide* is also being distributed at all dental trade shows and through all endorsing constituent dental societies.

Resolutions: This report is informational in nature and no resolutions are presented.

Notes

ADA Audit, 1995

Notes

Association Finances: A Joint Letter from the Treasurer and the Executive Director

Introduction

The financial position of the American Dental Association was again strengthened in calendar year 1995. A greater than expected increase in revenue in tandem with a concerted effort to control expenses contributed to this favorable result. Specifically, sales of educational and professional materials and receipts from testing services were greater than anticipated, and when coupled with underspending in travel, employee compensation, facility and publication costs, helped to generate an operating surplus of $2,624,517 where a deficit of $2,608,500 had been projected.

Expansion of Association for-profit activities in recent years has led to the creation of various subsidiary corporations. For purposes of disclosing the financial activities of these companies, separate audits were conducted for each entity. Even though these corporations function independently on a daily basis, the net results affect the Association's financial standing, as detailed in the consolidated financial statements.

In addition, audit reports for the American Dental Association Relief Fund and the ADA Endowment and Assistance Fund, Inc., are also included. The ADA Emergency Fund Board of Directors chose not to retain an independent firm to audit its financial statements given the level of revenue in fiscal 1995.

ADA and Subsidiary Operations

Audit Report: The accounting firm of Grant Thornton, upon completion of their annual audit, expressed an unqualified opinion on the 1995 financial statements of the Association and its subsidiaries.

In 1995, the Association and its subsidiaries were required to adopt two new accounting pronouncements, Statements of Financial Accounting Standards (SFAS) No. 116, Accounting for Contributions Received and Contributions Made, and No. 117, Financial Statements of Not-for-Profit Organizations, that modified the format and disclosures of the financial statements, as well as changed the method of accounting for certain contributions. These revisions primarily affected the American Dental Association Health Foundation (ADAHF) and the consolidated statements of the Association, and also involved restatement of 1994 financial results as required by the standards.

The comments which follow relate to the audit reports of the Association and its subsidiaries.

General Overview of Financial Statements: The financial statements reflect revenues and expenses separated into natural account categories. In addition to the basic consolidated statements of financial position, activities and cash flows, the 1995 audit report includes supplementary "consolidating" statements for the ADA and all of its subsidiary companies.

The purpose of these additional statements is to provide further detail regarding the components of the ADA General Fund and to depict the financial results of each subsidiary. The Operating Division is displayed in total and by its Operating, Investment, Capital Improvement Account, Building Fund and ADA Online 2000 (information technology project) elements. The Reserve Division is separated into its Capital Formation and Restricted accounts.

In addition, the American Dental Association Health Foundation; the American Dental Real Estate Corporation; and ADA Holding Company, Inc., consolidated with its subsidiaries, ADA Publishing Company, Inc., and ADA Financial Services Company, Inc., are also displayed. The format of the report includes a column entitled "Eliminations," which is used to remove the double-counting that invariably develops from transactions between a parent company and its subsidiaries.

Consolidated Association Statement of Financial Position: Favorable financial results for 1995 enabled the Association to increase its equity position, on a consolidated basis, by $10.5 million.

The most significant change affecting the statement of financial position was the increase in marketable securities investments by $11.4 million, primarily attributed to the Reserve Division Restricted Investment Account. Repositioning the Association's reserve investments to implement new strategies resulted in the liquidation of numerous security positions at net gains. The investment balance was also increased by the transfer of available 1994 surplus funds and a buildup in the Capital Improvement and Building Fund account balances.

Consolidated Association Revenues and Expenses: Revenues of $71,987,340 represent an improvement from the previous year mainly due to investment income from reshifting the reserve account portfolio coupled with increased sales of educational and professional materials. Expenses increased 6.6% from the previous year to $61,502,762. After consideration of an income tax benefit, consolidated net revenues in excess of expenses totaled $10,502,041.

Investment Account Analysis: The investment accounts of the Association are segregated into three categories: Capital Formation, which holds long-term investments that are not easily liquidated such as the Washington Office Building and the for-profit subsidiaries; Operating Division Investment Account, which consists of investments readily convertible to cash; and the Reserve Division Restricted Investment Account, which primarily comprises investments in mutual funds, common stocks and U.S. government securities.

Following is a recap of year-end balances for the five-year period ended December 31, 1995. These balances represent the total equity in each account including capital stock.

Recap of Year-End Balances

Investment Accounts

Year Ended	Operating Division	Capital Formation	Reserve Restricted	Total Investment
1991	$3,231,064	$1,693,815	$8,257,359	$13,182,238
1992	3,965,571	1,586,866	9,011,467	14,563,904
1993	3,814,349	4,827,963	10,313,542	18,955,854
1994	3,964,247	4,973,952	14,569,169	23,507,368
1995	4,169,398	4,328,051	18,879,689	27,377,138

The following table illustrates the portion of the Reserve Account balances invested in marketable securities that could be liquidated to satisfy future contingencies of the Association. Therefore, it excludes the Capital Formation account balances, which are not easily liquidated, and the Reserve Restricted Account's loan receivable from the Capital Improvement Account of $3.5 million plus accrued interest.

Recap of Marketable Security Balances

Investment Accounts

Year Ended	Operating Division	Capital Formation	Reserve Restricted	Total Investment
1991	$3,231,064	-	$8,257,359	$11,488,423
1992	3,965,571	-	5,511,467	9,477,038
1993	3,814,349	-	6,706,209	10,520,558
1994	3,964,247	-	10,804,169	14,768,416
1995	4,169,398	-	18,879,689	23,049,087

Capital Improvement Account Analysis: Continuing work on the Capital Improvement Program during 1995 resulted in remodeling and asbestos abatement improvements to the Headquarters Building totaling $514,435. The completed work was supported by $5,930,094 of membership dues restricted by House resolution as the primary funding source for this program. This four-year $55 dues increase is effective from 1993 to 1996. During 1995, the Capital Improvement Account repaid its outstanding obligation of $3.5 million plus accrued interest of $337,554 to the Restricted Reserve Account which represented a temporary transfer of funds authorized by Board resolution.

The program, which affects primarily tenant space, extends through the year 2000 and anticipates total capital expenditures approximating $18.5 million plus any interest on bank and reserve borrowings used to finance the project. Through December 31, 1995, improvements with the following costs, net of depreciation, have been completed:

Asbestos abatement	$3,169,442
Remodeling	7,365,827
	10,535,269
Less accumulated depreciation	1,697,246
	$8,838,023

Subsidiary Operations: In 1995, the for-profit subsidiaries generated a consolidated net after-tax loss of $41,389, compared with 1994 net earnings of $763,909. This decrease of $805,298 is largely attributable to the operations of ADA Financial Services Company, Inc., which is phasing in its product offerings for marketing and administrative purposes, as well as decreased earnings of ADA Publishing Company, Inc.

Although exhibiting favorable results from rental operations, after inclusion of depreciation and interest expense, American Dental Real Estate Corporation (ADREC) experienced an after-tax loss of $604,513 for 1995. While representing a significant shortfall, this deficit should be considered with the fact that the Association occupies its Washington premises rent-free, an imputed value of almost $250,000. This partially compensates for the economic losses of ADREC. Recognizing that income generated from building rentals is insufficient to support future interest and principal payments, the Association has committed to fund ADREC's cash flow losses up to $1.7 million annually.

As discussed earlier, ADAHF adopted two new accounting pronouncements in 1995 that increased reported net income since certain receipts were now includable in revenue that would previously have been deferred. In 1995, ADAHF exhibited net income of $1,001,421 compared with earnings of $506,437 in 1994, as adjusted to comply with new accounting rules. This increase is attributable to higher contributions and royalties not fully offset by expenditures. ADAHF received a grant from the Association of $2,170,435 in 1995 as compared with $1,607,145 in 1994.

ADA General Fund Operating Account

ADA Operating Results: The 1995 budget approved by the House of Delegates projected a funding deficit of $2,608,500. Actual results show net income before taxes of $2,649,471. Inclusion of $24,954 in tax expense generated an after-tax gain of $2,624,517.

This surplus from 1995 operations resulted in a transfer of $804,289 from the ADA General Fund to the Reserve Division Restricted Investment Account in accordance with Board Resolution B-54-1996. A reconciliation of surplus funds and the amount transferred to reserves is shown below.

1995 Surplus	$2,624,517
Less:	
Funded Depreciation (already transferred)	1,000,000
Provision for ADREC cash flow loss	335,580
Provision for deferral of ADREC capital expenditures	272,939
Provision for 1995 spending on information technology project	521,824
Due from reserves— Ohio Dental Association litigation**	17,877
Due from reserves— Grassroots Campaign**	195,500
Adjustment for pension expense	389,885
Add:	
Dividends Received from ADAHC	700,000
Restore amounts due from reserves—	
Ohio Dental Association litigation**	17,877
Grassroots Campaign**	195,500
Available Funds for Transfer to Reserves	$ 804,289

**These expenses were initially made from the Operating Account, reducing its surplus, and were to be reimbursed by the Reserve Restricted Account. Given the 1995 surplus, reserve monies meant to support these activities will be replenished.

This transfer was made with full recognition that present and prospective commitments exist for the use of these funds. Specifically, it is anticipated that such monies may be required to absorb an expected cash flow shortfall of $1,679,600 relating to the Washington, D.C. property in 1996 and to support an investment up to $5.6 million for upgrading computer capabilities to increase productivity and enhance member services.

Variance to Budget: The $804,289 transferred to reserves from 1995 operating results represents a $3,412,789 favorable variance from the budgeted deficit of $2,608,500. This difference is explained by the following items.

Revenues. Major variances in the sources of revenues compared with budget are described in the following table.

Increase in sales of educational and professional materials primarily related to *CDT-2*	$1,252,582
Annual session revenues from programs in Las Vegas	793,458
Receipts in excess of budget resulting from increased participation levels in educational testing	349,971
Decline in royalty income, primarily from the ADA Credit Card program, due to the early termination of the MBNA contract	(1,333,968)
Revenues from Seal Program submission and maintenance fees below budget	(316,960)
All other revenue variances, net favorable	98,805
Total	$ 843,888

Expenses and Other Items. Major variances between actual and budgeted amounts are shown in the following table.

Net savings in employee compensation, taxes and benefits	$ 2,260,782
Underspending in meeting and travel expense	712,927
Savings in publication and project costs	679,687
Savings in facility and utility costs	721,738
Las Vegas annual session, expenses higher than budgeted	(266,352) (a)
Funding of ADREC's cash flow loss from reserves and therefore not included in the operating budget	(335,580)
Deferral of ADREC capital expenditures funded from reserves and therefore not included in the operating budget	(272,939)
ADA Online 2000 project expenditures incurred and supported by reserves	(521,824)
Remaining expense and other item variances, net unfavorable	(409,538)
Total	$ 2,568,901

(a) Excludes costs shown separately above for compensation, publication and project, facilities, meeting and travel.

Conclusion

The Association actively represented the profession in 1995 before the 104th Congress and the Administration on issues ranging from AIDS and amalgam to student aid and wastewater. These activities were augmented where appropriate by the efforts of the ADA's Grassroots network of over 14,000 dentists and spouses. The introduction of H.R. 2400, the Family Health Care Fairness Act, which provides for consumer choice for patients and due process for doctors, is a strong step towards addressing many of the profession's concerns about managed care plans. The Association also worked to increase dentistry's presence, through such efforts as having dentists appointed to the White House Conference on Aging and the HIV-AIDS Council.

Beyond legislation, the Association pursued important legal issues for dentistry with various federal agencies, including the Department of Justice, the Occupational Safety and Health Administration (OSHA), the Federal Trade Commission and the Centers for Disease Control and Prevention. The Association successfully negotiated with OSHA to establish the special phone/fax method of investigating complaints against dental offices. In addition, the Association supported cases to maintain the profession's ethical standards on professional advertising and specialty announcement, and to preserve the rights of dentists to participate in benefit plans. To help the profession avoid legal difficulties, the Association has provided seminars and written materials on managed care and has helped constituent societies plan their efforts on direct reimbursement. The Association has continued to file friend-of-the-court briefs in appropriate cases that have a substantial impact on the dental profession nationally.

Rapid changes in the dental care marketplace were perceived by most members as a challenge to the viability of their practices. They were called upon to make significant practice choices. The most important activity of the Association in 1995 was a multifaceted educational effort to provide members, the public and dental benefit plan purchasers with important information to assist them in making informed decisions about their involvement with managed care and free choice dental plans.

Other major activities of the Association involved support for advances in dental research and education, licensure and clinical practice; continued focus on the Health Foundation's expanded mission; and the initial year of operations for ADA Financial Services Company, Inc.

Throughout 1995, the Association's limited resources were allocated on a priority basis to provide quality service to the profession, members and the public.

Treasurer

Executive Director

Report of Independent Certified Public Accountants

The Board of Trustees
American Dental Association

We have audited the accompanying consolidated statements of financial position of American Dental Association and subsidiaries as of December 31, 1995 and 1994, and the related consolidated statements of activities and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Association's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the consolidated financial position of American Dental Association and subsidiaries as of December 31, 1995 and 1994, and the consolidated results of their operations and their consolidated cash flows for the years then ended in conformity with generally accepted accounting principles.

As discussed in note 1 to the financial statements, in 1995 the Association adopted the provisions of Statements of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made" and 117, "Financial Statements of Not-for-Profit Organizations".

As discussed in note 1 to the financial statements, in 1995 the Association changed its method of accounting for postretirement benefits in accordance with Statement of Financial Accounting Standard No. 106, "Employer's Accounting for Postretirement Benefits other than Pensions".

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole of the American Dental Association and subsidiaries as of and for the years ended December 31, 1995 and 1994. The consolidating information included in Schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 1995 consolidated financial statements taken as a whole.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

American Dental Association and Subsidiaries

Consolidated Statements of Financial Position

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash and cash equivalents	$ 6,396,385	4,900,977
Receivables, net of allowance for doubtful accounts of $128,200 in 1995 and $101,500 in 1994	1,772,345	2,264,930
Deferred taxes and income taxes receivable (Note 7)	1,247,456	995,813
Inventories, net of reserves of $236,700 in 1995 and $425,800 in 1994	1,326,712	1,111,154
Marketable securities, at market (Note 2)	37,127,709	25,705,994
Property and equipment, net (Note 3)	20,949,225	20,269,085
Other real estate (Note 3)	11,031,493	11,323,080
Funds held for deferred compensation (Note 5)	3,067,666	2,565,539
Prepaid expenses and other assets (Note 8)	1,735,167	1,355,172
TOTAL ASSETS	$84,654,158	70,491,744
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable	$ 3,562,581	2,362,609
Accrued liabilities (Note 8)	3,128,329	2,425,798
Accrued pension liability (Note 8)	1,119,755	1,509,640
Notes payable (Note 6)	9,200,000	9,200,000
Deferred revenues	7,720,080	6,079,086
Liability for deferred compensation (Note 5)	3,067,666	2,565,539
Other liabilities	63,227	58,593
TOTAL LIABILITIES	27,861,638	24,201,265
Net assets (Note 9):		
Unrestricted	56,139,955	45,735,587
Temporarily restricted	652,565	554,892
TOTAL NET ASSETS	56,792,520	46,290,479
TOTAL LIABILITIES AND NET ASSETS	$84,654,158	70,491,744

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Consolidated Statements of Activities

Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Membership dues	$35,387,465	35,247,314
Advertising and subscriptions	8,194,413	7,985,078
Rental income	6,323,634	5,762,777
Sales of educational materials	5,412,082	3,964,929
Educational testing fees	3,296,271	2,938,720
Grants and contributions (including temporarily restricted contributions of $165,124 in 1995 and $205,791 in 1994)	4,010,964	3,430,723
Meeting and seminar registration fees	879,985	553,639
Investment income	3,815,651	875,908
Other income	4,666,875	5,511,876
Net assets released from restrictions (Note 9)	-	-
TOTAL REVENUES	71,987,340	66,270,964
EXPENSES (Note 10)		
Staff compensation, taxes and benefits (Note 8)	27,017,059	24,088,307
Publication and project expenses	11,581,835	10,936,179
Meeting and travel expenses	5,751,763	5,273,401
Professional services	5,530,548	6,317,148
Facility and utility expenses	3,639,149	3,705,042
Office expenses	2,862,141	2,822,216
Depreciation and amortization	2,676,815	2,459,164
Interest expense	719,497	719,017
Other expenses	1,723,955	1,389,131
TOTAL EXPENSES	61,502,762	57,709,605
Increase in net assets before income taxes	10,484,578	8,561,359
Income tax (benefit) expense (Note 7)	(17,463)	518,333
Increase in net assets	10,502,041	8,043,026
Net assets at beginning of year	46,290,479	38,247,453
Net assets at end of year	$56,792,520	46,290,479

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Consolidated Statements of Cash Flows

Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 10,502,041	8,043,026
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation and amortization	2,676,815	2,459,164
Deferred income taxes	15,178	83,944
Unrealized depreciation in market value of marketable securities	1,859,682	286,613
(Gain) loss on sale of marketable securities	(2,642,139)	42,577
Changes in assets and liabilities:		
Receivables, net	492,585	(193,546)
Deferred taxes and income taxes receivable	(266,821)	73,669
Inventories	(215,558)	149,567
Prepaid expenses and other assets	(382,188)	157,131
Accounts payable and accrued liabilities	1,902,503	(1,043,225)
Income taxes payable	-	(38,538)
Accrued pension liability	(389,885)	(545,589)
Deferred revenues	1,640,994	(613,752)
Other liabilities	4,634	(6,255)
Net cash provided by operating activities	15,197,841	8,854,786
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(51,542,122)	(37,846,355)
Sale and maturity of marketable securities	40,902,864	30,297,852
Organization costs incurred	-	(10,967)
Acquisitions of property, equipment and other real estate	(3,063,175)	(2,120,414)
Net cash used by investing activities	(13,702,433)	(9,679,884)
Net increase (decrease) in cash and cash equivalents	1,495,408	(825,098)
Cash and cash equivalents at beginning of year	4,900,977	5,726,075
Cash and cash equivalents at end of year	$ 6,396,385	4,900,977
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for:		
Interest	$ 716,680	716,680
Income taxes	$ 243,000	431,750
Cash received during the year for tax refunds	$ -	25,083

See accompanying notes to consolidated financial statements.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: The American Dental Association (Association) is organized as an association of members of the dental profession and is designed, as its corporate purpose states, "to encourage the improvement of the health of the public and to promote the art and science of dentistry."

The accompanying consolidated financial statements include the accounts of the Operating and Reserve Divisions of the Association; the American Dental Association Health Foundation (ADAHF); the Association's wholly-owned not-for-profit real estate corporation, American Dental Real Estate Corporation (ADREC); and the Association's wholly-owned for-profit subsidiary, ADA Holding Company, Inc. (ADAHC), and its wholly-owned subsidiaries, ADA Publishing Company, Inc. (ADAPCO) and ADA Financial Services Co. (FINCO). FINCO was incorporated on August 4, 1994. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Fair Value of Financial Instruments: The Association's financial instruments include cash and cash equivalents, marketable securities and notes payable. The carrying value of the cash and cash equivalents and notes payable approximates their estimated fair values based upon quoted market prices. The fair value of investments in marketable securities is estimated based on quotes from brokers or current rates offered for instruments with similar characteristics.

Cash Equivalents: Cash equivalents at December 31, 1995 and 1994 consist primarily of interest bearing deposits under overnight repurchase agreements.

Marketable Securities: Investments in marketable securities are carried at fair value. Realized and unrealized investment gains and losses are included within investment income in the accompanying consolidated financial statements.

Marketable securities held in the Operating Division are available for current use while marketable securities held in the Reserve Division are not intended for current use. In the event of emergency situations, Reserve Division assets may be used for operations upon approval of the Board of Trustees, with subsequent reporting to the Association's House of Delegates. Investment expenses of $71,293 and $42,116 in 1995 and 1994, respectively, are included in professional services in the accompanying consolidated financial statements.

Inventories: Inventories, consisting principally of salable educational materials and supplies, are carried at the lower of cost or market (net realizable value). Cost is determined using the first-in, first-out method.

Investment in Land: The Association's investment in land is carried at cost.

Property and Equipment: Property, equipment and leasehold improvements are stated at cost, less accumulated depreciation and amortization. Depreciation is computed on the straight-line method over the estimated useful lives of the assets which are as follows:

Buildings	30-55 years
Building improvements	7-20 years
Furniture, equipment and libraries	3-20 years

Tenant leasehold improvements are amortized over the shorter of their estimated useful life or the remaining term of the lease.

Deferred Compensation: Investments held for deferred compensation are carried at market value and are not available for current use.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

Revenue and Expense Recognition: Membership dues are recognized as income during the membership year which ends on December 31. Amounts received in advance are deferred to the subsequent year. Unearned membership dues, which have been included in deferred revenues in the accompanying consolidated financial statements, amounted to approximately $4,965,000 and $3,530,000 at December 31, 1995 and 1994, respectively.

Subscriptions to periodicals are recognized as income over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related periodical is issued.

Rental income from the Association's Headquarters Building and Washington Office building is recorded as revenue when earned. Also included in rental income is exhibit space rentals.

Testing fees are recognized as income when the related examinations are administered.

Grants received are recognized as income when costs of the related programs or projects are incurred. Amounts received but not yet expended are reported as deferred revenues in the accompanying consolidated financial statements. Grants to other organizations are recorded as expense when authorized by the Board of Trustees.

Contributions are recognized as revenues in the period pledged and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses.

Pension Costs: Pension costs are determined under the projected unit credit cost method. This method determines the present value of benefits accrued to date under the provisions of the pension plan and ignores any further benefit accruals.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Adoption of Accounting Standards: In 1995, the Association adopted the provisions of Statements of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made", and 117, "Financial Statements of Not-for-Profit Organizations". In accordance with these Standards, all not-for-profit organizations are required to classify contributions based on the existence or absence of donor-imposed restrictions. Net assets subject to donor-imposed stipulations are to be classified as temporarily restricted net assets while net assets not subject to such restrictions are to be classified as unrestricted net assets. The Association is also required to present statements of financial position, activities and cash flows in accordance with the provisions of the Standards.

In connection with the implementation of SFAS Nos. 116 and 117 and the capitalization of 1994 laboratory equipment purchases previously expensed, total net assets as of December 31, 1994 and 1993 have been adjusted as follows:

	1994	1993
Net assets as previously reported	$44,698,660	37,165,311
Adjustment to reclassify deferred revenue from liabilities to net assets	1,474,039	1,082,142
Adjustment to capitalize 1994 purchases of laboratory equipment	130,867	-
Adjustment to record depreciation expense on laboratory equipment	(13,087)	-
Net assets as restated	$46,290,479	38,247,453

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

Furthermore, during 1995 the Association adopted Statement of Financial Accounting Standard No. 106, "Employer's Accounting for Postretirement Benefits Other than Pensions". This Standard requires the recognition of postretirement benefits over employees' service periods. Previously, the Association was recognizing such costs on the cash basis. Adoption of SFAS 106 increased expenses by $396,560.

New Accounting Standard: Statement of Financial Accounting Standard No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to Be Disposed Of" was issued and will be adopted by ADREC in 1996. The impact of adopting this Standard is not determinable at December 31, 1995. However, it is possible that the carrying value of real estate for financial statement purposes may change as a result of adoption of SFAS 121 in consideration of appraisals or other information that may be accumulated with respect to the real estate's value.

Reclassifications: Certain 1994 amounts have been reclassified to conform to the 1995 presentation.

2. Marketable Securities

Marketable securities at December 31, 1995 and 1994 consisted of the following:

	1995		1994	
	Cost	Market	Cost	Market
Money market funds	$15,203,752	15,203,752	16,340,337	16,340,337
Certificates of deposit	2,992,187	2,992,187	2,593,300	2,593,300
U.S. government obligations	2,898,273	2,818,410	12,919	12,964
Corporate bonds	533,819	522,574	-	-
Mutual funds	11,974,790	12,772,657	-	-
Common stocks	3,524,888	3,660,204	6,759,438	5,741,786
	$37,127,709	37,969,784	25,705,994	24,688,387

The fair value of marketable securities held in the Reserve Division amounted to $19,263,073 and $10,777,471 at December 31, 1995 and 1994, respectively.

Gross unrealized appreciation and depreciation on marketable securities amounted to $375,411 and $1,217,486 as of December 31, 1995 and $1,257,514 and $239,862 as of December 31, 1994.

3. Property and Equipment and Other Real Estate

Property and equipment at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Land	$ 712,113	712,113
Building	12,381,169	12,381,169
Building improvements	16,912,729	15,589,323
Furniture and equipment	10,653,782	9,040,301
Film and book libraries	483,828	455,629
Tenant leasehold improvements	615,347	775,481
	41,758,968	38,954,016
Less accumulated depreciation and amortization	20,809,743	18,684,931
	$20,949,225	20,269,085

Depreciation and amortization expense related to property, equipment and tenant leasehold improvements for the years ended December 31, 1995 and 1994 amounted to $2,291,475 and $2,060,481, respectively.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

Building improvements at December 31, 1995 and 1994, include the following costs related to a renovation and asbestos abatement program for the Association's Headquarters building:

	1995	1994
Asbestos abatement	$ 3,169,442	2,903,860
Remodeling	7,365,827	7,116,974
	10,535,269	10,020,834
Less accumulated depreciation	1,697,246	1,027,417
	$ 8,838,023	8,993,417

This program, which affects primarily tenant space, will extend through the year 2000, having estimated total capital expenditures of $18.5 million, plus interest on borrowings used to finance the project. In 1992, the House of Delegates approved a four year $55 dues increase for Association members, which is effective from 1993 to 1996 relating to this program. These revenues are restricted for the specific purpose of financing remodeling and asbestos abatement activities and as such are classified, along with related assets, liabilities and expenses in the Capital Improvement Account within the Operating Division.

Other real estate, located in Washington, D.C., consisted of the following at December 31, 1995 and 1994:

	1995	1994
Land	$ 3,030,000	3,030,000
Building	9,602,195	9,602,195
Building improvements	383,573	358,870
Building equipment	84,941	84,941
Tenant leasehold improvements	363,142	294,092
	13,463,851	13,370,098
Less accumulated depreciation and amortization	2,432,358	2,047,018
	$11,031,493	11,323,080

Depreciation and amortization expense on other real estate for the years ended December 31, 1995 and 1994, amounted to $385,340 and $398,683, respectively.

The Association leases portions of both the Headquarters Building and the Washington Office building to unrelated parties under operating leases with varying terms. These amounts may be adjusted upon renewal of the leases. Also included in rental income is $3,162,000 and $2,575,000 of exhibit space rentals for 1995 and 1994, respectively. Minimum future rentals to be earned from leases currently in effect are:

1996	$ 2,629,388
1997	2,199,214
1998	1,931,705
1999	1,183,221
2000	1,058,796
Thereafter	3,830,888
	$12,833,212

Building expenses include the cost of facilities occupied by the Association, as well as those costs related to other tenants.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

4. ADA Online 2000 Project

The Association has initiated a project to upgrade its information technology systems by replacing the mainframe and related software supporting core applications. This project, referred to as ADA Online 2000, anticipates total expenditures of $5.6 million including capital purchases of software and hardware as well as expense items such as consulting and training.

At December 31, 1995 property and equipment includes the following costs related to this project:

	1995
Computer software and hardware	$ 441,299
Less accumulated depreciation	(44,130)
	$ 397,169

Additionally, during 1995, a total of $124,655 was expensed in the following categories for this activity:

	1995
Publication and project expenses	$ 10
Meeting and travel expenses	5,550
Professional services	74,883
Office expenses	82
Depreciation	44,130
	$ 124,655

5. Deferred Compensation

Pursuant to agreements between the Association and certain officers and employees, portions of their compensation have been set aside and invested as directed by those participants. The assets are owned by the Association until distributed to the participants after termination of employment or services.

6. Notes Payable

In February 1989, ADREC purchased the building constructed on land in Washington, D.C. owned by the Association for $9,500,000. The mortgage loan existing at December 31, 1992 was refinanced during 1993 by issuing notes of the corporation.

Notes payable at December 31, 1995 and 1994 consisted of the following:

	1995	1994
LONG-TERM NOTES PAYABLE		
7.79% Guaranteed Senior Notes, due February 1, 2005, with monthly interest payments on unpaid principal balance. Annual principal payments of $920,000 commencing February 1, 1996 through maturity. Guaranteed by the Association.	$9,200,000	9,200,000

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

7. Income Taxes

The Association, ADAHF and ADREC are exempt from taxation on income related to their exempt purposes under sections 501(c)(6), 501(c)(3) and 501(c)(2) of the Internal Revenue Code (Code), respectively. As exempt organizations, the Association, ADAHF and ADREC are subject to federal and state income taxes on income determined to be unrelated business taxable income. The income of the Association's for-profit subsidiaries, determined separately, is also subject to federal and state income taxes.

The Association files consolidated income tax returns with ADREC. ADAHC files consolidated income tax returns with ADAPCO and FINCO. ADAHF files its own tax return.

Income tax (benefit) expense for the years ended December 31, 1995 and 1994 is as follows:

	1995	1994
Current:		
Federal	$ (41,448)	315,261
State	8,807	119,128
Current income tax (benefit) expense	(32,641)	434,389
Deferred:		
Federal	12,495	106,406
State	2,683	(22,462)
Deferred income tax expense	15,178	83,944
Income tax (benefit) expense	$ (17,463)	518,333

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense primarily because the majority of consolidated income is exempt from income tax.

Deferred taxes and income taxes receivable at December 31, 1995 and 1994 consisted of:

	1995	1994
Deferred tax assets resulting from:		
Start-up expenses	$ 147,635	157,722
Alternative minimum tax credits	22,944	22,944
Excess of the tax basis over book basis of receivables, net	23,969	23,969
	194,548	204,635
Deferred tax liability resulting from excess of book basis over tax basis of furniture and equipment, net	(80,328)	(75,237)
Deferred tax assets, net	114,220	129,398
Federal and state income taxes receivable resulting from net operating loss carrybacks, amended tax returns and current refunds	1,133,236	866,415
	$1,247,456	995,813

During the year ended December 31, 1994 ADAPCO realized a benefit of $121,735, resulting from the use of net operating loss carryforwards generated in prior years. As of December 31, 1994 ADAPCO had no remaining net operating loss carryforwards.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

ADREC's non-exempt operating results are included in the income tax returns of the Association. Under the terms of an informal tax allocation agreement between ADREC and the Association, ADREC is paid for the tax benefits used by the Association in its income tax returns. ADREC has recorded income tax benefits (expense) of $8,529 in 1995 and $(16,379) in 1994 under the terms of this arrangement.

As of December 31, 1995, ADREC had net operating loss carryforwards totalling approximately $965,000 available to offset future unrelated business taxable income, expiring as follows: $136,300 in 2007, $194,700 in 2008, $277,200 in 2009 and $356,900 in 2010. These carryforwards, because of uncertainty of realization, are not reflected as deferred tax assets.

8. Employee Benefit Plans

The Association sponsors a noncontributory defined benefit pension plan which covers substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Pursuant to agreements between the Association and certain prior employees, the Association maintains frozen unfunded supplemental retirement income plan. Generally, the Association's funding policy is to contribute annually to the pension plan such amounts that may be deducted for Federal income tax purposes. Retirement benefit payments are based on years of credited service, average compensation during the final five years of employment, and the average Social Security limit at employment termination date.

Investments designated for the supplemental plan of $582,535 and $479,068 at December 31, 1995 and 1994, respectively, are carried at fair value and included in prepaid expenses and other assets.

The following table sets forth the plans' funded status and amounts recognized in the Association's consolidated financial statements:

	1995			
	Employees' Retirement Trust	Employees' Supplemental Trust	Total	1994 Total
Actuarial present value of benefit obligations:				
Accumulated benefit obligation, including vested benefits of $20,620,202 and $969,058 in 1995 and $16,124,196 and $901,967 in 1994, respectively	$21,338,161	969,058	22,307,219	17,588,748
Projected benefit obligation for services rendered to date	$26,446,955	969,058	27,416,013	21,818,197
Plan assets at fair value, primarily bonds, stocks and insurance guarantee contracts	21,210,039	-	21,210,039	16,990,906
Projected benefit obligation in excess of plan assets	(5,236,916)	(969,058)	(6,205,974)	(4,827,291)
Unrecognized net loss from past experience different from that assumed and effects of changes in assumptions	4,611,866	274,224	4,886,090	3,035,504
Prior service cost not yet recognized in net periodic pension cost	262,809	-	262,809	363,573
Unrecognized net asset at January 1, 1987 being recognized over 15 years	(62,680)	-	(62,680)	(81,426)
Accrued pension expense included in accrued pension payable	$ (424,921)	(694,834)	(1,119,755)	(1,509,640)
Net periodic pension cost for 1995 and 1994 included the following components:				
Service cost-benefits earned during the period	$ 1,382,108	-	1,382,108	1,310,827
Interest cost on projected benefit obligation	1,660,083	70,059	1,730,142	1,580,688
Actual return on plan assets	(2,761,257)	-	(2,761,257)	432,624
Net amortization and deferral	1,249,323	2,595	1,251,918	(1,881,857)
Net periodic pension cost	$ 1,530,257	72,654	1,602,911	1,442,282

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

The weighted-average discount rate and rate of increase in future compensation levels used in determining the actuarial present value of the projected benefit obligation were 7.5% and 5%, respectively, for 1995 and were 8% and 5.25%, respectively, for 1994. The expected long-term rate of return on assets was 10%. The discount rate and rate of increase in future compensation levels used at the beginning of the year to determine net periodic pension cost were 8% and 5.25% for 1995 and 7.5% and 5% for 1994, with the rate of return assumption the same as described above.

The Association has a savings and retirement plan for all eligible employees. The Association matches 25% of contributed amounts up to a maximum of $250 per participant each year. The Association's contributions under this plan were $76,205 in 1995 and $71,804 in 1994.

The Internal Revenue Service has informed the Savings and Employees' Retirement Trust administrators that the plans are qualified under provisions of the Code and, therefore, the related trusts are exempt from federal income taxes. The Employees' Supplemental Trust is a nonqualified plan and as such is not exempt from federal income taxes.

The Association has established the Executive Parity Plan which compensates Association executives who suffered restrictions in their pension benefits beginning in 1994 as a result of the Omnibus Budget Reconciliation Act. This is a deferred compensation arrangement which allows the Compensation Committee of the Board of Trustees to set aside, on an annual basis, a specified cash amount for those individuals who suffered a benefit loss during the year, to be paid upon vesting. Awards totalling $105,042 (reflected in prepaid expenses and other assets) were granted in aggregate for 1994 and 1995, of which no payments were made to participants.

The Association sponsors a contributory defined benefit postretirement health plan which covers substantially all employees of the Association and its subsidiaries. The plan provides both medical and dental benefits.

In 1995 the Association recorded a liability of $396,560 (reflected in accrued liabilities) for these benefits upon adoption of Statement of Financial Accounting Standards (SFAS) No. 106, "Employers' Accounting for Postretirement Benefits Other Than Pensions". The following table sets forth the plan's funded status:

	1995
Accumulated postretirement benefit obligation:	
Retired participants	$ (2,395,245)
Fully eligible active participants	(142,923)
Other active participants	(1,505,339)
	(4,043,507)
Plan assets at fair value	-
Accumulated postretirement benefit obligation in excess of plan assets	(4,043,507)
Unrecognized net loss based on experience differing from assumptions	183,214
Prior service cost not yet recognized	-
Unrecognized transition obligation	3,463,733
Accrued postretirement benefit cost	$ (396,560)
Net periodic postretirement benefit cost for 1995 included in the following components:	
Service cost	$ 159,465
Interest cost on accumulated postretirement benefit obligation	282,483
Amortization of transition obligation	182,302
Net periodic postretirement benefit cost	$ 624,250

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

The assumed health care cost trend rate used to measure the Association's expected cost of covered medical benefits was 6% for 1995. The plan limits annual increases in the Association's cost of benefits to no more than 6%. The assumed health care cost trend rate used to measure the expected cost of covered dental benefits was 6% for 1995 and for each year thereafter. The assumed discount rate used to measure the obligation is 7.5%. A 1% increase in the assumed health care cost trend rate would increase the accumulated postretirement benefit obligation at December 31, 1995 by $603,570 and the service cost for the year then ended by $34,422.

The past service obligation at transition amounted to $3,646,035 at January 1, 1995. This obligation is being amortized over a 20-year period.

9. Temporarily Restricted Net Assets

The following activity impacted unrestricted and temporarily restricted net assets during 1995 and 1994:

	1995			1994		
	Unrestricted	Temporarily Restricted	Total	Unrestricted	Temporarily Restricted	Total
Revenue	$71,790,984	196,356	71,987,340	66,041,931	229,033	66,270,964
Net assets released from restrictions	98,683	(98,683)	-	109,640	(109,640)	-
Total revenues	71,889,667	97,673	71,987,340	66,151,571	119,393	66,270,964
Expenses Including income taxes	61,485,299	-	61,485,299	58,227,938	-	58,227,938
Change in net assets	10,404,368	97,673	10,502,041	7,923,633	119,393	8,043,026
Net assets at beginning of year	45,735,587	554,892	46,290,479	37,811,954	435,499	38,247,453
Net assets at end of year	$56,139,955	652,565	56,792,520	45,735,587	554,892	46,290,479

Temporarily restricted net assets are available for the following purposes:

	1995	1994
Trusts and endowments	$ 524,799	500,367
Awards	102,135	48,441
Education	11,248	25
Research	10,066	6,053
Access	4,317	6
	$ 652,565	554,892

Trusts and endowments include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

American Dental Association and Subsidiaries

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

10. Expenses by Functional Classification

The following table summarizes the costs of providing various programs and activities on a functional basis:

	1995	1994
Administration and Policy	$3,580,369	3,620,386
Legal Affairs	1,950,650	1,731,580
Government Affairs	2,748,923	2,539,332
Communications	2,324,846	2,267,634
Membership and Dental Society Services	3,334,726	3,086,886
Conference and Meeting Services	4,590,660	4,346,976
Finance and Operations	3,780,552	3,525,425
Headquarters Building	3,584,453	3,480,625
Saleable Materials	2,942,140	2,928,728
Central Administration	3,142,181	3,133,924
Dental Practice	3,581,828	3,047,388
Education and Science	128,056	-
Education	5,149,795	5,076,919
Science	1,503,113	1,540,994
Grant to ADAHF from ADA	2,170,435	1,607,145
Survey Center	1,449,795	1,346,547
Information Technology	1,938,049	1,726,633
Grassroots Campaign	-	820,644
	47,900,571	45,827,766
Capital Improvement Account	742,383	759,428
Building Fund	632,874	603,900
ADA Online 2000 Project	124,655	-
Reserve Division Restricted Account	71,293	42,116
Eliminations of intercompany activity -		
Interest expense	(72,554)	(162,005)
Grant to ADAHF from ADA	(2,170,435)	(1,607,145)
ADAPCO Production Services Fee	(82,460)	-
Overhead recovery	476,434	430,469
	47,622,761	45,894,529
ADAHF	4,934,567	4,207,498
ADREC	1,697,046	1,860,806
ADAHC (for-profit activities)	9,416,264	8,355,423
Eliminations of intercompany activity -		
Interest expense-FINCO	(10,675)	-
ADAPCO and ADREC rental charges	(231,004)	(217,131)
Overhead recovery and ADAPCO royalty	(1,183,660)	(1,113,187)
ADAPCO contract fee	(760,000)	(760,000)
	$61,485,299	58,227,938

11. Commitments and Contingencies

The Association is involved in various asserted and unasserted claims incidental to the normal conduct of its business. In the opinion of management and the Association's legal counsel, the ultimate disposition of these matters will not have a material adverse effect on the consolidated results of operations or financial position of the Association.

American Dental Association and Subsidiaries
Consolidating Statement of Financial Position
December 31, 1995

	General Fund													
	Operating Division						Reserve Division							
	Operating Account	Investment Account	Capital Improvement Account	Building Fund	ADA On-Line 2000	Total	Capital Formation Account	Restricted Account	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
ASSETS														
Cash and cash equivalents	$ 4,632,857	-	-	-	-	4,632,857	-	-	4,632,857	142,723	25,615	1,595,190	-	6,396,385
Receivables, net	578,622	-	-	-	-	578,622	700,000	61,533	1,340,155	142,589	-	989,601	(700,000)	1,772,345
Due from (to) affiliates	(290,508)	-	797,903	(189,070)	(521,824)	(203,499)	1,114,595	71,560	982,656	5,214	(324,253)	(663,617)	-	-
Deferred taxes and income taxes receivable	828,698	-	-	-	-	828,698	-	-	828,698	-	-	418,758	-	1,247,456
Inventories, net	1,326,712	-	-	-	-	1,326,712	-	-	1,326,712	-	-	-	-	1,326,712
Marketable securities, at market	984,021	4,169,398	7,584,261	2,154,396	-	14,892,076	-	19,263,073	34,155,149	2,972,560	-	-	-	37,127,709
Investment in subsidiaries	-	-	-	-	-	-	(516,544)	-	(516,544)	-	-	-	516,544	-
Property and equipment, net	3,177,351	-	8,838,023	7,861,522	397,169	20,274,065	-	-	20,274,065	375,434	-	299,726	-	20,949,225
Other real estate	-	-	-	-	-	-	3,030,000	-	3,030,000	-	8,001,493	-	-	11,031,493
Funds held for deferred compensation	3,067,666	-	-	-	-	3,067,666	-	-	3,067,666	-	-	-	-	3,067,666
Prepaid expenses and other assets	1,697,618	-	-	-	-	1,697,618	-	-	1,697,618	-	167,285	175,264	(305,000)	1,735,167
Total assets	$ 16,003,037	4,169,398	17,220,187	9,826,848	(124,655)	47,094,815	4,328,051	19,396,166	70,819,032	3,638,520	7,870,140	2,814,922	(488,456)	84,654,158
LIABILITIES AND NET ASSETS														
Liabilities:														
Accounts payable	$ 2,714,372	-	181,280	10,825	-	2,906,477	-	-	2,906,477	189,311	60,015	406,778	-	3,562,581
Accrued liabilities	2,409,767	-	-	-	-	2,409,767	-	516,477	2,926,244	38,536	-	863,549	(700,000)	3,128,329
Accrued pension liability	1,119,755	-	-	-	-	1,119,755	-	-	1,119,755	-	-	-	-	1,119,755
Notes payable	-	-	-	-	-	-	-	-	-	-	9,200,000	305,000	(305,000)	9,200,000
Deferred revenues	5,927,847	-	827,446	-	-	6,755,293	-	-	6,755,293	661,750	-	303,037	-	7,720,080
Liability for deferred compensation	3,067,666	-	-	-	-	3,067,666	-	-	3,067,666	-	-	-	-	3,067,666
Other liabilities	-	-	-	-	-	-	-	-	-	-	63,227	-	-	63,227
Total liabilities	15,239,407	-	1,008,726	10,825	-	16,258,958	-	516,477	16,775,435	889,597	9,323,242	1,878,364	(1,005,000)	27,861,638
Net Assets:														
Common stock	-	-	-	-	-	-	-	-	-	-	100	100	(200)	-
Additional paid-in capital	-	-	-	-	-	-	-	-	-	-	2,716,433	500,000	(3,216,433)	-
Unrestricted	763,630	4,169,398	16,211,461	9,816,023	(124,655)	30,835,857	4,328,051	18,879,689	54,043,597	2,096,358	(4,169,635)	436,458	3,733,177	56,139,955
Temporarily Restricted	-	-	-	-	-	-	-	-	-	652,565	-	-	-	652,565
Total net assets	763,630	4,169,398	16,211,461	9,816,023	(124,655)	30,835,857	4,328,051	18,879,689	54,043,597	2,748,923	(1,453,102)	936,558	516,544	56,792,520
Total liabilities and net assets	$ 16,003,037	4,169,398	17,220,187	9,826,848	(124,655)	47,094,815	4,328,051	19,396,166	70,819,032	3,638,520	7,870,140	2,814,922	(488,456)	84,654,158

See accompanying report of independent certified public accountants.

Schedule 1

American Dental Association and Subsidiaries
Consolidating Statement of Activities
Year Ended December 31, 1995

	General Fund														
	Operating Division						Reserve Division								
	Operating Account	Investment Account	Capital Improvement Account	Building Fund	ADA On-Line 2000	Total	Capital Formation Account	Restricted Account	Elimination	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
Revenues:															
Membership dues	$ 29,457,371	-	5,930,094	-	-	35,387,465	-	-	-	35,387,465	-	-	-	-	35,387,465
Advertising and subscriptions	-	-	-	-	-	-	-	-	-	-	-	-	8,194,413	-	8,194,413
Rental income	5,462,104	-	-	-	-	5,462,104	-	-	-	5,462,104	-	1,092,533	-	(231,003)	6,323,634
Sales of educational materials	5,412,082	-	-	-	-	5,412,082	-	-	-	5,412,082	-	-	-	-	5,412,082
Educational testing fees	3,296,271	-	-	-	-	3,296,271	-	-	-	3,296,271	-	-	-	-	3,296,271
Grants and contributions	406,113	-	-	-	-	406,113	-	-	-	406,113	5,775,286	-	-	(2,170,435)	4,010,964
Meeting and seminar registration fees	879,985	-	-	-	-	879,985	-	-	-	879,985	-	-	-	-	879,985
Investment income	555,401	205,151	344,566	102,631	-	1,207,749	(645,902)	2,510,767	(72,554)	3,000,060	160,702	-	19,662	635,227	3,815,651
Other income	5,055,761	-	-	-	-	5,055,761	1	-	-	5,055,762	-	-	1,160,800	(1,549,687)	4,666,875
Total revenues	50,525,088	205,151	6,274,660	102,631	-	57,107,530	(645,901)	2,510,767	(72,554)	58,899,842	5,935,988	1,092,533	9,374,875	(3,315,898)	71,987,340
Expenses:															
Staff compensation, taxes and benefits	22,101,360	-	-	-	-	22,101,360	-	-	-	22,101,360	2,914,797	17,804	1,983,098	-	27,017,059
Publication and project expenses	5,579,213	-	-	-	10	5,579,223	-	-	-	5,579,223	251,864	-	5,750,748	-	11,581,835
Meeting and travel expenses	5,420,673	-	-	-	5,550	5,426,223	-	-	-	5,426,223	195,525	-	130,015	-	5,751,763
Professional services	4,680,314	-	-	-	74,883	4,755,197	-	71,293	-	4,826,490	324,960	33,185	345,913	-	5,530,548
Facility and utility expenses	3,081,262	-	-	-	-	3,081,262	-	-	-	3,081,262	-	543,652	230,237	(216,002)	3,639,149
Office expenses	2,468,554	-	-	-	82	2,468,636	-	-	-	2,468,636	266,678	6,097	135,731	(15,001)	2,862,141
Grants to health related groups	2,170,435	-	-	-	-	2,170,435	-	-	-	2,170,435	-	-	-	(2,170,435)	-
Depreciation and amortization	827,207	-	669,829	632,874	44,130	2,174,040	-	-	-	2,174,040	60,857	385,340	56,578	-	2,676,815
Interest expense	-	-	72,554	-	-	72,554	-	-	(72,554)	-	-	719,497	10,675	(10,675)	719,497
Other expenses	1,546,599	-	-	-	-	1,546,599	-	-	-	1,546,599	919,886	-	807,157	(1,549,687)	1,723,955
Total expenses	47,875,617	-	742,383	632,874	124,655	49,375,529	-	71,293	(72,554)	49,374,268	4,934,567	1,705,575	9,450,152	(3,961,800)	61,502,762
Increase (decrease) in net assets before income taxes	2,649,471	205,151	5,532,277	(530,243)	(124,655)	7,732,001	(645,901)	2,439,474	-	9,525,574	1,001,421	(613,042)	(75,277)	645,902	10,484,578
Income tax expense (benefit)	24,954	-	-	-	-	24,954	-	-	-	24,954	-	(8,529)	(33,888)	-	(17,463)
Increase (decrease) in net assets	2,624,517	205,151	5,532,277	(530,243)	(124,655)	7,707,047	(645,901)	2,439,474	-	9,500,620	1,001,421	(604,513)	(41,389)	645,902	10,502,041
Net assets at beginning of year	1,010,159	3,964,247	10,679,184	9,346,266	-	24,999,856	4,973,952	14,569,169	-	44,542,977	1,747,502	(3,565,122)	1,177,847	2,387,275	46,290,479
Equity transfer	(2,871,046)	-	-	1,000,000	-	(1,871,046)	-	1,871,046	-	-	-	-	-	-	-
Dividends	-	-	-	-	-	-	-	-	-	-	-	-	(700,000)	700,000	-
Net assets at end of year	$ 763,630	4,169,398	16,211,461	9,816,023	(124,655)	30,835,857	4,328,051	18,879,689	-	54,043,597	2,748,923	(4,169,635)	436,458	3,733,177	56,792,520

See accompanying report of independent certified public accountants.

American Dental Association and Subsidiaries
Consolidating Statement of Cash Flows
Year Ended December 31, 1995

	General Fund													
	Operating Division						Reserve Division							
	Operating Account	Investment Account	Capital Improvement Account	Building Fund	ADA On-Line 2000	Total	Capital Formation Account	Restricted Account	Total General Fund	ADAHF	ADREC	ADAHC	Eliminations	Total
Cash flows from operating activities:														
Increase (decrease) in net assets	$ 2,624,517	205,151	5,532,277	(530,243)	(124,655)	7,707,047	(645,901)	2,439,474	9,500,620	1,001,421	(604,513)	(41,389)	645,902	10,502,041
Adjustments to reconcile increase (decrease) in net assets to net cash provided (used) by operating activities:														
Depreciation and amortization	827,207	-	669,829	632,874	44,130	2,174,040	-	-	2,174,040	60,857	385,340	56,578	-	2,676,815
Deferred income taxes	-	-	-	-	-	-	-	-	-	-	-	15,178	-	15,178
Unrealized (appreciation) depreciation in market value of marketable securities	-	-	-	-	-	-	-	1,859,727	1,859,727	(45)	-	-	-	1,859,682
Gain on sale of marketable securities	-	-	-	-	-	-	-	(2,642,139)	(2,642,139)	-	-	-	-	(2,642,139)
Equity in earnings of subsidiaries	-	-	-	-	-	-	645,902	-	645,902	-	-	-	(645,902)	-
Changes in assets and liabilities:														
Receivables, net	612,863	-	-	-	-	612,863	-	(34,835)	578,028	5,283	-	(90,726)	-	492,585
Due from/to affiliated organizations	(382,633)	-	(3,908,181)	4,702	521,824	(3,764,288)	(105,591)	3,693,440	(176,439)	(169,931)	(31,589)	377,959	-	-
Deferred taxes and income taxes receivable	25,245	-	-	-	-	25,245	-	-	25,245	-	-	(292,066)	-	(266,821)
Inventories	(215,558)	-	-	-	-	(215,558)	-	-	(215,558)	-	-	-	-	(215,558)
Prepaid expenses and other assets	(614,915)	-	-	-	-	(614,915)	-	-	(614,915)	-	(25,999)	(46,274)	305,000	(382,188)
Accounts, dividends payable and accrued liabilities	1,077,804	-	152,187	(34,447)	-	1,195,544	-	516,477	1,712,021	(6,356)	(1,289)	198,127	-	1,902,503
Accrued pension liability	(389,885)	-	-	-	-	(389,885)	-	-	(389,885)	-	-	-	-	(389,885)
Deferred revenues	1,502,782	-	239,101	-	-	1,741,883	-	-	1,741,883	(82,826)	-	(18,063)	-	1,640,994
Other liabilities	-	-	-	-	-	-	-	-	-	-	4,634	-	-	4,634
Net cash provided (used) by operating activities	5,067,427	205,151	2,685,213	72,886	441,299	8,471,976	(105,590)	5,832,144	14,198,530	808,403	(273,416)	159,324	305,000	15,197,841
Cash flows from investing activities:														
Purchase of marketable securities	-	(205,151)	(2,170,778)	(257,766)	-	(2,633,695)	-	(18,531,250)	(21,164,945)	(30,377,177)	-	-	-	(51,542,122)
Investment in subsidiary	-	-	-	-	-	-	(294,410)	-	(294,410)	-	-	-	294,410	-
Sale and maturity of marketable securities	83,050	-	-	-	-	83,050	-	10,828,060	10,911,110	29,991,754	-	-	-	40,902,864
Acquisitions of property, equipment and other real estate	(843,684)	-	(514,435)	(815,120)	(441,299)	(2,614,538)	-	-	(2,614,538)	(308,278)	(93,753)	(46,606)	-	(3,063,175)
Net cash (used) by investing activities	(760,634)	(205,151)	(2,685,213)	(1,072,886)	(441,299)	(5,165,183)	(294,410)	(7,703,190)	(13,162,783)	(693,701)	(93,753)	(46,606)	294,410	(13,702,433)
Cash flows from financing activities:														
Proceeds from note payable, affiliate	-	-	-	-	-	-	-	-	-	-	-	305,000	(305,000)	-
Additional investment from ADA	-	-	-	-	-	-	-	-	-	-	294,410	-	(294,410)	-
Receipt (Payment) of dividends	-	-	-	-	-	-	400,000	-	400,000	-	-	(400,000)	-	-
Net cash provided (used) by financing activities	-	-	-	-	-	-	400,000	-	400,000	-	294,410	(95,000)	(599,410)	-
Net increase (decrease) in cash and cash equivalents	4,306,793	-	-	(1,000,000)	-	3,306,793	-	(1,871,046)	1,435,747	114,702	(72,759)	17,718	-	1,495,408
Cash and cash equivalents at beginning of year	3,197,110	-	-	-	-	3,197,110	-	-	3,197,110	28,021	98,374	1,577,472	-	4,900,977
Equity transfers	(2,871,046)	-	-	1,000,000	-	(1,871,046)	-	1,871,046	-	-	-	-	-	-
Cash and cash equivalents at end of year	$ 4,632,857	-	-	-	-	4,632,857	-	-	4,632,857	142,723	25,615	1,595,190	-	6,396,385

See accompanying report of independent certified public accountants.

Schedule 3

Report of Independent Certified Public Accountants

The Board of Directors
American Dental Association Health Foundation

We have audited the accompanying statements of financial position of American Dental Association Health Foundation as of December 31, 1995 and 1994, and the related statements of activities, and cash flows for the years then ended. These financial statements are the responsibility of the Foundation's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards and *Government Auditing Standards* issued by the Comptroller General of the United States. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Association Health Foundation as of December 31, 1995 and 1994, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

As discussed in Note 1 to the financial statements, in 1995 the American Dental Association Health Foundation adopted the provisions of Statement of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made" and 117, "Financial Statements of Not-for-Profit Organizations".

In accordance with *Government Auditing Standards*, we have also issued a report dated March 29, 1996 on our consideration of American Dental Association Health Foundation's internal control structure and a report dated March 29, 1996 on its compliance with laws and regulations.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

American Dental Association Health Foundation

Statements of Financial Position

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash	$ 142,723	28,021
Unbilled contract revenues and reimbursable grant expenses	142,589	147,872
Marketable securities, at market (Note 2)	2,972,560	2,587,092
Due from (to) American Dental Association (Note 8)	5,214	(164,717)
Furniture and equipment, net (Note 3)	375,434	128,013
TOTAL ASSETS	$3,638,520	2,726,281
LIABILITIES AND NET ASSETS		
Liabilities:		
Accounts payable	$ 189,311	203,823
Accrued liabilities	38,536	30,380
Deferred revenues (Note 4)	661,750	744,576
TOTAL LIABILITIES	889,597	978,779
Net assets:		
Unrestricted	2,096,358	1,192,610
Temporarily restricted (Note 6)	652,565	554,892
TOTAL NET ASSETS	2,748,923	1,747,502
TOTAL LIABILITIES AND NET ASSETS	$3,638,520	2,726,281

See accompanying notes to financial statements.

American Dental Association Health Foundation

Statements of Activities

Years Ended December 31, 1995 and 1994

	1995			1994		
	Unrestricted	Temporarily Restricted	Total	Unrestricted	Temporarily Restricted	Total
REVENUE						
Government contracts and grants	$ 1,779,990	-	1,779,990	1,903,198	-	1,903,198
Royalties and unrestricted contributions	941,328	-	941,328	612,062	-	612,062
Trusts, endowments, awards and restricted contributions	-	165,124	165,124	-	205,791	205,791
Corporate grants	718,409	-	718,409	284,715	-	284,715
American Dental Association grant (Note 8)	2,170,435	-	2,170,435	1,607,145	-	1,607,145
Investment income, net	129,470	31,232	160,702	77,782	23,242	101,024
Net assets released from restrictions	98,683	(98,683)	-	109,640	(109,640)	-
TOTAL REVENUE	5,838,315	97,673	5,935,988	4,594,542	119,393	4,713,935
EXPENSES (Note 7)						
Staff compensation, taxes and benefits (Note 8)	2,914,797	-	2,914,797	2,418,404	-	2,418,404
Meeting and travel expenses	195,525	-	195,525	130,121	-	130,121
Laboratory and office expenses	266,678	-	266,678	255,166	-	255,166
Professional services	324,960	-	324,960	340,954	-	340,954
Direct publication and project costs	251,864	-	251,864	160,562	-	160,562
Depreciation	60,857	-	60,857	17,738	-	17,738
Other expenses, including indirect costs (Note 8)	919,886	-	919,886	884,553	-	884,553
TOTAL EXPENSES	4,934,567	-	4,934,567	4,207,498	-	4,207,498
Increase in net assets	903,748	97,673	1,001,421	387,044	119,393	506,437
Net assets at beginning of year (Note 1)	1,192,610	554,892	1,747,502	805,566	435,499	1,241,065
Net assets at end of year	$ 2,096,358	652,565	2,748,923	1,192,610	554,892	1,747,502

See accompanying notes to financial statements.

American Dental Association Health Foundation

Statements of Cash Flows

Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase in net assets	$ 1,001,421	506,437
Adjustments to reconcile increase in net assets to net cash provided by operating activities:		
Depreciation	60,857	17,738
Net unrealized (appreciation) depreciation of marketable securities	(45)	231
Changes in assets and liabilities:		
Unbilled contract revenues and reimbursable grant expenses	5,283	(39,423)
Accounts payable and accrued liabilities	(6,356)	137,122
Due from/to American Dental Association	(169,931)	57,147
Deferred revenues	(82,826)	(78,657)
Net cash provided by operating activities	808,403	600,595
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(30,377,177)	(7,555,541)
Sale and maturity of marketable securities	29,991,754	7,100,000
Acquisition of equipment	(308,278)	(134,113)
Net cash used in investing activities	(693,701)	(589,654)
Net increase in cash	114,702	10,941
Cash at beginning of year	28,021	17,080
Cash at end of year	$ 142,723	28,021

See accompanying notes to financial statements.

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: The American Dental Association Health Foundation (Foundation), an affiliated foundation of the American Dental Association (Association), was organized to operate exclusively for charitable, scientific and educational purposes.

The Foundation is an Illinois not-for-profit corporation.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Marketable Securities: Marketable securities are carried at fair value and are available for current use. The fair values of the marketable securities are estimated based on quotes from brokers or current rates offered for instruments with similar characteristics.

Revenue Recognition: Contributions, which are defined as nonreciprocal transfers, are recognized as revenues in the period pledged and classified according to the existence or absence of donor-imposed restrictions. When a donor restriction has been satisfied by incurring expenses consistent with the designated purpose, temporarily restricted net assets are reclassified to unrestricted net assets for reporting of related expenses.

Corporate grants that do not constitute contributions are recognized as income when costs of the related programs or projects are incurred. Corporate grants received but not yet expended are reported as deferred revenues.

Contributed Facilities: The Foundation occupies without charge certain premises located in government-owned research facilities. No amounts have been reflected in the financial statements for their use as no objective basis is available to measure the value of such facilities.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over the estimated useful lives of the assets, which is five to ten years.

Adoption of Accounting Standards: In 1995, the Foundation adopted the provisions of Statements of Financial Accounting Standards (SFAS) Nos. 116, "Accounting for Contributions Received and Contributions Made", and 117, "Financial Statements of Not-for-Profit Organizations". In accordance with these Standards, all not-for-profit organizations are required to classify contributions and net assets based on the existence or absence of donor-imposed restrictions. Net assets subject to donor-imposed stipulations are to be classified as temporarily restricted net assets while net assets not subject to such restrictions are to be classified as unrestricted net assets. The Foundation is also required to present statements of financial position, activities and cash flows in accordance with the provisions of the Standards.

In connection with the implementation of SFAS Nos. 116 and 117 and the capitalization of 1994 laboratory equipment purchases previously expensed, total net assets as of December 31, 1994 and 1993 have been adjusted as follows:

	1994	1993
Net assets as previously reported	$ 155,683	158,923
Adjustment to reclassify deferred revenue from liabilities to net assets	1,474,039	1,082,142
Adjustment to capitalize 1994 purchases of laboratory equipment	130,867	-
Adjustment to record depreciation expense on laboratory equipment	(13,087)	-
Net assets as restated	$1,747,502	1,241,065

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

Reclassifications: Certain 1994 amounts have been reclassified to conform to the 1995 presentation.

2. Marketable Securities

Marketable securities at December 31, 1995 and 1994 consisted of the following:

	1995		1994	
	Cost	Market	Cost	Market
Certificates of deposit	$2,972,560	2,972,560	2,574,173	2,574,173
U.S. government obligations	-	-	12,964	12,919
	$2,972,560	2,972,560	2,587,137	2,587,092

3. Furniture and Equipment

Furniture and equipment at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Furniture and equipment	$ 714,038	405,760
Less accumulated depreciation	338,604	277,747
	$ 375,434	128,013

4. Changes in Deferred Revenues

The following represents changes in deferred revenues:

	1995	1994
Balances at beginning of year	$ 744,576	823,233
Additions - grants	635,583	206,058
Deductions—funds expended during the year	(718,409)	(284,715)
Balances at end of year	$ 661,750	744,576

5. Income Taxes

The Foundation is exempt from taxation on income related to its exempt purpose under Section 501(c)(3) of the Internal Revenue Code. There was no significant unrelated business income in 1995 or 1994 and therefore a provision for income taxes was not required.

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

6. Temporarily Restricted Net Assets

Temporarily restricted net assets at December 31, 1995 and 1994 are available for the following purposes:

	1995	1994
Trusts and endowments	$ 524,799	500,367
Awards	102,135	48,441
Education	11,248	25
Research	10,066	6,053
Access	4,317	6
	$ 652,565	554,892

Trusts and endowments include funds restricted by donors for periodontal research, public education in dental health and memorial commemoration.

7. Expenses by Functional Classification

The following table summarizes the costs of providing various programs or activities on a functional basis:

	1995	1994
Association sponsored research	$1,664,406	1,351,989
Federal government sponsored research	1,727,754	1,835,946
Corporate and donor sponsored programs relating to research, education, access and awards	949,677	605,984
Fundraising	182,001	189,119
Administrative and general	349,872	206,722
Depreciation	60,857	17,738
	$4,934,567	4,207,498

8. Transactions With Related Parties

The Foundation receives an annual grant from the Association for the Foundation's research activities sponsored by the Association. The grant amounted to $2,170,435 and $1,607,145 in 1995 and 1994, respectively. The Foundation receives financial and administrative services from the Association as may be required. In 1995 and 1994, the Foundation paid $693,013 and $716,621, respectively, for such services.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Included in the amounts described above are pension expense charges associated with the Foundation's employees' participation in the Association's retirement plans. These expenses, which amounted to $196,965 and $212,578 for 1995 and 1994, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of Foundation employees.

American Dental Association Health Foundation

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

In addition, during 1995 the Association and its Subsidiaries adopted Statement of Financial Accounting Standards No. 106, "Employer's Accounting for Postretirement Benefits other than Pensions". Included in the allocated expenses described above are postretirement benefit charges of $47,150 associated with participating Foundation employees. The effect of adopting this Standard was not significant.

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
American Dental Real Estate Corporation

We have audited the accompanying balance sheets of American Dental Real Estate Corporation (a wholly-owned subsidiary of American Dental Association) as of December 31, 1995 and 1994, and the related statements of revenues, expenses and accumulated deficit, and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Real Estate Corporation as of December 31, 1995 and 1994, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Balance Sheets

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash and cash equivalents	$ 25,615	98,374
Building, equipment and tenant leasehold improvements, net (Note 2)	8,001,493	8,293,080
Prepaid expenses and other assets	167,285	141,286
TOTAL ASSETS	$8,194,393	8,532,740
LIABILITIES AND STOCKHOLDER'S DEFICIT		
Liabilities:		
Notes payable (Note 4)	$9,200,000	9,200,000
Accounts payable and accrued liabilities	60,015	61,304
Due to American Dental Association	324,253	355,842
Other liabilities	63,227	58,593
TOTAL LIABILITIES	9,647,495	9,675,739
Stockholder's equity (deficit):		
Common stock, $1 par value; Authorized 1,000 shares; issued and outstanding 100 shares	100	100
Additional paid-in capital (Note 5)	2,716,433	2,422,023
Accumulated deficit	(4,169,635)	(3,565,122)
TOTAL STOCKHOLDER'S DEFICIT	(1,453,102)	(1,142,999)
TOTAL LIABILITIES AND STOCKHOLDER'S DEFICIT	$8,194,393	8,532,740

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Statements of Revenues, Expenses and Accumulated Deficit

Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Building income, principally rentals	$ 1,092,533	1,242,885
EXPENSES		
Staff compensation, taxes and benefits	17,804	17,576
Facility costs, including utilities	543,652	665,592
Professional services	33,185	26,295
Office expenses	6,097	5,523
Depreciation and amortization	385,340	398,683
Interest expense	719,497	719,017
Other expenses	-	11,741
TOTAL EXPENSES	1,705,575	1,844,427
Excess of expenses over revenues before income tax benefit (expense)	(613,042)	(601,542)
Income tax benefit (expense) (Note 3)	8,529	(16,379)
Excess of expenses over revenues	(604,513)	(617,921)
Accumulated deficit at beginning of year	(3,565,122)	(2,947,201)
Accumulated deficit at end of year	$(4,169,635)	(3,565,122)

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Statements of Cash Flows

Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Excess of expenses over revenues	$ (604,513)	(617,921)
Adjustments to reconcile excess of expenses over revenues to net cash used by operating activities:		
Depreciation and amortization	385,340	398,683
Changes in assets and liabilities:		
Due to American Dental Association	(31,589)	(551,290)
Prepaid expenses and other assets	(25,999)	(5,507)
Accounts payable and accrued liabilities	(1,289)	46,171
Other liabilities	4,634	(6,255)
Net cash used by operating activities	(273,416)	(736,119)
NET CASH USED BY INVESTING ACTIVITIES -		
Acquisition of building, equipment and tenant leasehold improvements	(93,753)	(109,581)
CASH FLOWS FROM FINANCING ACTIVITIES -		
Additional investment from American Dental Association (Note 5)	294,410	-
Net decrease in cash and cash equivalents	(72,759)	(845,700)
Cash and cash equivalents at beginning of year	98,374	944,074
Cash and cash equivalents at end of year	$ 25,615	98,374
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for interest	$ 716,680	716,680

See accompanying notes to financial statements.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: American Dental Real Estate Corporation (ADREC), a wholly-owned subsidiary of the American Dental Association (Association), was organized as a not-for-profit corporation for the exclusive purpose of holding title to the Association's Washington Office building, collecting rental income thereon, and remitting the net income to the Association.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents: Cash equivalents at December 31, 1995 and 1994 consist of deposits under overnight repurchase agreements which are carried at their fair value.

Building, Equipment and Tenant Leasehold Improvements: Building, equipment and tenant leasehold improvements are carried at cost, net of accumulated depreciation and amortization. Depreciation is computed on the straight-line method over the estimated useful lives of the assets, which are 30 years for the building and building improvements, and seven years for equipment. Tenant leasehold improvements are amortized over the shorter of their estimated useful lives or the remaining term of the lease.

Revenue Recognition: Building rental income is recorded as revenue when earned.

New Accounting Standard: Statement of Financial Accounting Standard No. 121, "Accounting for the Impairment of Long-Lived Assets and for Long-Lived Assets to Be Disposed Of" was issued and will be adopted by ADREC in 1996. The impact of adopting this Standard is not determinable at December 31, 1995. However, it is possible that the carrying value of real estate for financial statement purposes may change as a result of adoption of SFAS 121 in consideration of appraisals or other information that may be accumulated with respect to the real estate's value.

2. Building, Equipment, and Tenant Leasehold Improvements

Building, equipment and tenant leasehold improvements at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Building	$ 9,602,195	9,602,195
Building improvements	383,573	358,870
Building equipment	84,941	84,941
Tenant leasehold improvements	363,142	294,092
	10,433,851	10,340,098
Less accumulated depreciation and amortization	2,432,358	2,047,018
	$ 8,001,493	8,293,080

ADREC leases portions of the building to unrelated parties under operating leases with varying terms. Minimum future rentals to be earned from non-cancelable leases currently in effect are $743,178 in 1996, $467,522 in 1997, $420,786 in 1998, $180,228 in 1999 and $74,700 in 2000. These amounts may change upon renewal of the leases.

American Dental Real Estate Corporation

(A wholly-owned subsidiary of American Dental Association)

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

3. Income Taxes

ADREC is exempt from taxation on income related to its exempt purpose under Section 501(c)(2) of the Internal Revenue Code. No federal or state income taxes were owed on unrelated business activities in 1995 or 1994 as such operations generated losses.

ADREC's non-exempt operating results are included in the income tax returns of the Association. Under the terms of an informal tax allocation agreement between ADREC and the Association, ADREC is paid for the tax benefits used by the Association in its income tax returns. ADREC has recorded income tax benefit (expense) of $8,529 in 1995 and $(16,379) in 1994 under this arrangement.

As of December 31, 1995, ADREC had net operating loss carryforwards totalling approximately $965,000 available to offset future unrelated business taxable income, expiring as follows: $136,300 in 2007, $194,700 in 2008, $277,200 in 2009, and $356,900 in 2010. These carryforwards, because of uncertainty of realization, are not reflected as deferred tax assets.

4. Notes Payable

In February 1989, ADREC purchased the building constructed on land owned by the Association for $9,500,000. The mortgage loan was refinanced during 1993 by issuing notes of the corporation. The carrying value of notes payable approximates fair value.

The notes payable at December 31, 1995 and 1994 consisted of the following:

	1995	1994
LONG-TERM NOTES PAYABLE		
7.79% Guaranteed Senior Notes, due February 1, 2005, with monthly interest payments on the unpaid principal balance. Annual principal payments of $920,000 commencing February 1, 1996 through maturity. Guaranteed by the Association.	$ 9,200,000	9,200,000

5. Additional Paid-In Capital

During 1995, the Association made an additional investment of $294,410 in ADREC. This investment satisfied the Association's commitment to fund ADREC's 1994 cash flow losses.

During 1993, the Association had made an additional investment of $2,422,023 to enable ADREC to repay existing loans and notes payable as well as legal and advisory fees incurred in connection with refinancing its remaining debt obligations.

6. Transactions With Related Parties

The Association occupies approximately 17% of space in the building owned by ADREC. The building owned by ADREC is situated on land owned by the Association. A nominal rental is exchanged in connection with these arrangements.

7. Liquidity

During 1995 and 1994, ADREC sustained significant operating deficits. The ability of ADREC to continue operating the rental property is dependent upon receipt of additional advances from the Association, to cover working capital requirements and capital improvements. The Association intends to provide funds to allow ADREC to meet its 1996 obligations.

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Holding Company, Inc.

We have audited the accompanying consolidated balance sheets of ADA Holding Company, Inc. (a wholly-owned subsidiary of American Dental Association) and subsidiaries as of December 31, 1995 and 1994, and the related consolidated statements of operations and retained earnings, and cash flows for the years then ended. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of ADA Holding Company, Inc. and subsidiaries as of December 31, 1995 and 1994, and the consolidated results of their operations and their consolidated cash flows for the years then ended in conformity with generally accepted accounting principles.

Our audits were conducted for the purpose of forming an opinion on the consolidated financial statements taken as a whole of the ADA Holding Company, Inc. and subsidiaries. The consolidating information included in Schedules 1 through 3 is presented for purposes of additional analysis and is not a required part of the consolidated financial statements. Such information has been subjected to the auditing procedures applied in the audit of the consolidated financial statements and, in our opinion, is fairly stated in all material respects in relation to the 1995 consolidated financial statements taken as a whole.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidated Balance Sheets

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash and cash equivalents	$1,595,190	1,577,472
Receivables, net of allowance for doubtful accounts of $60,000 in 1995 and 1994	989,601	898,875
Deferred taxes and income taxes receivable (Note 3)	418,758	141,870
Furniture and equipment, net (Note 2)	299,726	307,505
Other assets	175,264	131,183
TOTAL ASSETS	$3,478,539	3,056,905
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts, dividends payable and accrued liabilities	$1,270,327	772,200
Note payable, affiliate (Note 4)	305,000	-
Due to American Dental Association (Note 4)	663,617	285,658
Deferred revenues	303,037	321,100
TOTAL LIABILITIES	2,541,981	1,378,958
Stockholder's Equity:		
Common stock, $1 par value; Authorized 1,000 shares; issued and outstanding 100 shares	100	100
Additional paid-in capital	500,000	500,000
Retained earnings	436,458	1,177,847
TOTAL STOCKHOLDER'S EQUITY	936,558	1,677,947
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$3,478,539	3,056,905

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidated Statements of Operations and Retained Earnings

Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Advertising, including classified ads	$7,705,213	7,584,110
Subscriptions	489,200	400,968
Publishing fees (Note 4)	760,000	760,000
Investment income	19,662	30,406
Other income	400,800	343,848
TOTAL REVENUES	9,374,875	9,119,332
EXPENSES		
Staff compensation, taxes and benefits (Note 4)	1,983,098	1,639,534
Publication, printing and project expenses	5,750,748	4,858,677
Endorsement costs (Note 5)	281,096	-
Professional services	345,913	424,829
Facility and utility costs	230,237	215,137
Office expense	135,731	113,481
Meeting and travel expenses	130,015	103,239
Depreciation and amortization	56,578	48,764
Interest expense (Note 4)	10,675	-
Other expenses, including allocated general and administrative expenses (Note 4)	526,061	476,377
TOTAL EXPENSES	9,450,152	7,880,038
Income (loss) before income tax benefit (expense)	(75,277)	1,239,294
Income tax benefit (expense) (Note 3)	33,888	(475,385)
Net (loss) income	(41,389)	763,909
Retained earnings at beginning of year	1,177,847	1,238,938
Dividends declared	(700,000)	(825,000)
Retained earnings at end of year	$ 436,458	1,177,847

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidated Statements of Cash Flows

Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Net (loss) income	$ (41,389)	763,909
Adjustments to reconcile net (loss) income to net cash provided by operating activities:		
Depreciation and amortization	56,578	48,764
Deferred income taxes	15,178	83,944
Changes in assets and liabilities:		
Receivables, net	(90,726)	21,188
Income taxes receivable	(292,066)	(1,771)
Other assets	(46,274)	76,788
Accounts payable and accrued liabilities	198,127	(8,182)
Income taxes payable	-	(38,538)
Due to American Dental Association	377,959	349,580
Deferred revenues	(18,063)	114,288
Net cash provided by operating activities	159,324	1,409,970
CASH FLOWS FROM INVESTING ACTIVITIES		
Organization costs incurred	-	(10,967)
Acquisitions of furniture and equipment	(46,606)	(64,659)
Net cash used by investing activities	(46,606)	(75,626)
CASH FLOWS FROM FINANCING ACTIVITIES		
Proceeds from note payable, affiliate	305,000	-
Payment of dividends	(400,000)	(850,000)
Net cash used by financing activities	(95,000)	(850,000)
Net increase in cash and cash equivalents	17,718	484,344
Cash and cash equivalents at beginning of year	1,577,472	1,093,128
Cash and cash equivalents at end of year	$1,595,190	1,577,472
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for income taxes	$ 243,000	431,750
SUPPLEMENTAL SCHEDULE OF NONCASH FINANCING ACTIVITY		
Declared and unpaid dividends	$ 700,000	400,000

See accompanying notes to consolidated financial statements.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: ADA Holding Company, Inc. (ADAHC), a wholly-owned subsidiary of the American Dental Association (Association), was organized for the purpose of holding equity positions in, and managing, the for-profit corporations organized by the Association.

The accompanying consolidated financial statements include the accounts of ADAHC and its wholly-owned subsidiaries, ADA Publishing Co., Inc. (ADAPCO) and ADA Financial Services Co., Inc. (FINCO). FINCO, a development stage enterprise, was incorporated on August 4, 1995. All significant intercompany accounts and transactions have been eliminated in consolidation.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents: Cash equivalents at December 31, 1995 and 1994 consist of interest bearing deposits under overnight repurchase agreements, which are carried at their fair value.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten years, the estimated useful lives of the assets.

Other Assets: Postage deposits established in connection with ADAPCO's publishing operations are expensed as publications are mailed. Costs incurred in the establishment of FINCO have been capitalized and are being amortized on the straight-line method over a 60-month period.

Revenue and Expense Recognition: Subscriptions to periodicals are recognized as revenue over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related publication is issued. Endorsement costs are recognized when conditions for their accrual under the agreements with participating state societies or their subsidiaries are satisfied.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities, based upon enacted tax rates which would apply during the period in which taxes became payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Reclassifications: Certain 1994 amounts have been reclassified to conform to the 1995 presentation.

2. Furniture and Equipment

Furniture and equipment at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Furniture and equipment	$ 532,956	486,350
Less accumulated depreciation	233,230	178,845
	$ 299,726	307,505

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

3. Income Taxes

ADAHC files consolidated income tax returns with its wholly-owned subsidiaries.

Income tax benefit (expense) for the years ended December 31, 1995 and 1994, is as follows:

	1995	1994
Current:		
Federal	$ 41,448	(280,091)
State	7,618	(111,350)
Current income tax benefit (expense)	49,066	(391,441)
Deferred:		
Federal	(12,495)	(106,406)
State	(2,683)	22,462
Deferred income tax expense	(15,178)	(83,944)
Total income tax benefit (expense)	$ 33,888	(475,385)

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense for the years ended December 31, 1995 and 1994, as follows:

	1995	1994
Statutory federal income tax	$ 25,594	(421,360)
State income taxes	7,620	(111,520)
Over provision of prior year taxes	22,885	35,702
Other, net	(22,211)	21,793
Income tax benefit (expense)	$ 33,888	(475,385)

Deferred tax assets at December 31, 1995 and 1994 result primarily from differences in the book basis and tax basis of start-up expenses for FINCO. "Start-up" expenses represent operating costs of FINCO incurred prior to commencing substantial business operations. Under tax law these expenses are amortized using the straight-line method over a 60-month period following commencement of substantial business operations. For tax purposes, FINCO commenced substantial business operations on April 1, 1995. Deferred tax liabilities result from differences in the book basis and tax basis of furniture and equipment.

Deferred taxes and income taxes receivable at December 31, 1995 and 1994 consisted of:

	1995	1994
Deferred tax assets resulting from:		
Start-up expenses	$ 147,635	157,722
Alternative minimum tax credits	22,944	22,944
Excess of tax basis over book basis of receivables, net	23,969	23,969
	194,548	204,635
Deferred tax liability resulting from excess of book basis over tax basis of furniture and equipment, net	(80,328)	(75,237)
Deferred tax assets, net	114,220	129,398
Federal and state income taxes receivable	304,538	12,472
	$ 418,758	141,870

During the year ended December 31, 1994, ADAPCO realized a benefit of $121,735 resulting from the use of net operating loss carryforwards generated in prior years. At December 31, 1994, ADAPCO had no remaining net operating loss carryforwards.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Notes to Consolidated Financial Statements, December 31, 1995 and 1994 (continued)

4. Transactions With Related Parties

The Association provides ADAHC and its subsidiaries with administrative services as may be required. The allocated cost of such services amounted to $629,802 and $559,334 during the years ended December 31, 1995 and 1994, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Included in the allocated expenses described above are pension expense charges associated with ADAHC and its subsidiaries' employees who are participants in the Association's retirement plans. These expenses, which amounted to $138,713 and $128,865 in 1995 and 1994, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ADAHC and its subsidiaries.

In addition, during 1995 the Association and its subsidiaries adopted Statement of Financial Accounting Standards No. 106, "Employer's Accounting for Post Retirement Benefits other than Pensions". Included in the allocated expenses described above are post retirement benefit charges of $14,655 associated with participating employees. The effect of adopting this Standard was not significant.

The Association also leases equipment and office space to ADAPCO and office space to FINCO. Rent expense under these leases amounted to $231,002 and $217,129 during 1995 and 1994, respectively. The office space leases total $17,981 a month. These leases are on a month-to-month basis. Minimum future rentals to be paid for equipment leased under non-cancelable operating leases currently in effect are $15,000 for each year through 1999.

Effective January 1, 1990, the Association and ADA Publishers, Inc., a predecessor corporation to ADAPCO, entered into a publishing agreement which has been assigned to ADAPCO. The term of the agreement is five years with an option for automatic renewal for an additional five years, unless terminated by the parties pursuant to terms of the agreement. Under the terms of the agreement, ADAPCO performs all publishing and distribution functions related to the Association's three major publications and may include new publications developed in the future. In connection with the agreement, the Association assigned all relevant production and advertising contracts, together with all non-member subscriptions and the revenue from single copy sales, to ADAPCO. Under the terms of the agreement, the Association paid publishing fees in the amount of $760,000 during the years ended December 31, 1995 and 1994. Also under the terms of the agreement, a royalty fee was paid to the Association for the use of its trademarks in connection with its publishing activity. The royalty is payable at a rate of 2% of ADAPCO's pre-tax income. Royalties paid were approximately $14,200 in 1995 and $34,000 in 1994.

On July 1, 1995 the Association loaned FINCO $305,000 in exchange for an unsecured promissory note bearing simple interest at 7% per annum. The note is due July 1, 2000 and can be prepaid, in whole or in part, at any time without penalty. Interest expense amounted to $10,675 for the year ended December 31, 1995.

5. Endorsement Costs

On July 1, 1995 the Association ceased endorsing affinity cards and other financial products offered by Maryland Bank N.A. (MBNA) in favor of products offered by Mellon Bank and FINCO. During 1995 participating state dental societies or their related financial service subsidiaries entered into agreements with FINCO and the Association. These agreements require the state organizations to endorse FINCO's ADA1PLAN products to its members, in exchange for a share in the revenues generated by the program. The agreements also provide for different service fees or royalties depending upon the specific products involved. In addition, through December 31, 1996, the agreements guarantee participating organizations will receive, at a minimum, what they would have earned in the comparable period of the previous year by continuing to endorse the affinity card program with MBNA. Additionally, a new card fee of $40 is paid for each new affinity card opened in a participating state through December 31, 1996.

Endorsement costs for 1995 are comprised of these adjustment royalties and new card fees.

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidating Balance Sheet

December 31, 1995

	ADAHC	ADAPCO	FINCO	Eliminations	Consolidated ADAHC
ASSETS					
Cash and cash equivalents	$ 783,879	530,179	281,132	-	1,595,190
Receivables, net	-	981,946	7,655	-	989,601
Deferred taxes and income taxes receivable	418,758	-	-	-	418,758
Investment in ADAPCO	864,532	-	-	(864,532)	-
Investment in FINCO	(194,928)	-	-	194,928	-
Furniture and equipment, net	-	292,176	7,550	-	299,726
Other assets	-	167,221	8,043	-	175,264
TOTAL ASSETS	$ 1,872,241	1,971,522	304,380	(669,604)	3,478,539
LIABILITIES AND STOCKHOLDER'S EQUITY (DEFICIT)					
Liabilities:					
Accounts, dividends payable and accrued liabilities	$ 700,756	421,870	147,701	-	1,270,327
Note payable, affiliate	-	-	305,000	-	305,000
Due to affiliated organizations, net	234,927	382,083	46,607	-	663,617
Deferred revenues	-	303,037	-	-	303,037
TOTAL LIABILITIES	935,683	1,106,990	499,308	-	2,541,981
Stockholder's equity (deficit):					
Common stock	100	1,000,000	1,000	(1,001,000)	100
Additional paid-in capital	500,000	501,000	500,000	(1,001,000)	500,000
Retained earnings (deficit)	436,458	(636,468)	(695,928)	1,332,396	436,458
TOTAL STOCKHOLDER'S EQUITY (DEFICIT)	936,558	864,532	(194,928)	(669,604)	936,558
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY (DEFICIT)	$ 1,872,241	1,971,522	304,380	(669,604)	3,478,539

See accompanying report of independent certified public accountants.

Schedule 1

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidating Statement of Operations and Retained Earnings

Year Ended December 31, 1995

	ADAHC	ADAPCO	FINCO	Eliminations	Consolidated ADAHC
REVENUES					
Advertising, including classified ads	$ -	7,705,213	-	-	7,705,213
Subscriptions	-	489,200	-	-	489,200
Publishing fees	-	760,000	-	-	760,000
Investment income	-	19,662	-	-	19,662
Other income	-	383,866	20,581	(3,647)	400,800
TOTAL REVENUES	-	9,357,941	20,581	(3,647)	9,374,875
EXPENSES					
Staff compensation, taxes and benefits	-	1,852,049	131,049	-	1,983,098
Publication, printing and project expenses	121	5,744,602	6,025	-	5,750,748
Endorsement costs	-	-	281,096	-	281,096
Professional services	12,115	134,574	199,224	-	345,913
Facility and utility costs	-	215,325	14,912	-	230,237
Office expense	273	123,685	11,773	-	135,731
Meeting and travel expenses	782	80,959	48,274	-	130,015
Depreciation and amortization	-	53,621	2,957	-	56,578
Interest expense	-	-	10,675	-	10,675
Other expenses, including allocated general and administrative expenses	1,730	457,501	70,477	(3,647)	526,061
TOTAL EXPENSES	15,021	8,662,316	776,462	(3,647)	9,450,152
Income (loss) before income taxes	(15,021)	695,625	(755,881)	-	(75,277)
Income tax benefit (expense)	3,161	(261,209)	291,936	-	33,888
Income (loss) before equity in earnings (losses) of subsidiaries	(11,860)	434,416	(463,945)	-	(41,389)
Equity in losses of subsidiaries	(29,529)	-	-	29,529	-
Net income (loss)	(41,389)	434,416	(463,945)	29,529	(41,389)
Retained earnings (deficit) at beginning of year	1,177,847	129,116	(231,983)	102,867	1,177,847
Dividends declared	(700,000)	(1,200,000)	-	1,200,000	(700,000)
Retained earnings (deficit) at end of year	$ 436,458	(636,468)	(695,928)	1,332,396	436,458

See accompanying report of independent certified public accountants.

Schedule 2

ADA Holding Company, Inc. and Subsidiaries

(A wholly-owned subsidiary of American Dental Association)

Consolidating Statement of Cash Flows

Year Ended December 31, 1995

	ADAHC	ADAPCO	FINCO	Eliminations	Consolidated ADAHC
CASH FLOWS FROM OPERATING ACTIVITIES					
Net income (loss)	$ (41,389)	434,416	(463,945)	29,529	(41,389)
Adjustments to reconcile net income (loss) to net cash provided (used) by operating activities:					
Depreciation and amortization	-	53,621	2,957	-	56,578
Deferred income taxes	-	4,719	10,459	-	15,178
Equity in losses of subsidiaries, plus dividends	1,229,529	-	-	(1,229,529)	-
Changes in assets and liabilities:					
Receivables, net	-	(83,071)	(7,655)	-	(90,726)
Income taxes receivable	(276,888)	-	-	(15,178)	(292,066)
Other assets	-	(46,274)	-	-	(46,274)
Accounts payable and accrued liabilities	-	122,631	75,496	-	198,127
Due to affiliated organizations, net	299,968	196,579	(133,766)	15,178	377,959
Deferred revenues	-	(18,063)	-	-	(18,063)
Net cash provided (used) by operating activities	1,211,220	664,558	(516,454)	(1,200,000)	159,324
CASH FLOWS FROM INVESTING ACTIVITIES					
Additional capital contribution	(500,000)	-	-	500,000	-
Acquisitions of furniture and equipment	-	(38,292)	(8,314)	-	(46,606)
Net cash used by investing activities	(500,000)	(38,292)	(8,314)	500,000	(46,606)
CASH FLOWS FROM FINANCING ACTIVITIES					
Proceeds from note payable, affiliate	-	-	305,000	-	305,000
Proceeds from additional capital contribution	-	-	500,000	(500,000)	-
Payment of dividends	(400,000)	(1,200,000)	-	1,200,000	(400,000)
Net cash provided (used) by financing activities	(400,000)	(1,200,000)	805,000	700,000	(95,000)
Net increase (decrease) in cash and cash equivalents	311,220	(573,734)	280,232	-	17,718
Cash and cash equivalents at beginning of year	472,659	1,103,913	900	-	1,577,472
Cash and cash equivalents at end of year	$ 783,879	530,179	281,132	-	1,595,190

See accompanying report of independent certified public accountants.

Schedule 3

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Financial Services Company, Inc.

We have audited the accompanying balance sheets of ADA Financial Services Company, Inc. (a development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1995 and 1994 and the related statements of operations and accumulated deficit, and cash flows for the year ended December 31, 1995, the period from August 4, 1994 (inception) to December 31, 1994 and the period from August 4, 1994 to December 31, 1995. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ADA Financial Services Company, Inc. as of December 31, 1995 and 1994 and the results of its operations and its cash flows for the periods then ended and for the period from August 4, 1994 (inception) to December 31, 1995 in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

ADA Financial Services Company, Inc.

(A development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.)

Balance Sheets

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash	$ 281,132	900
Receivables	7,655	-
Furniture and equipment, net (Note 2)	7,550	-
Other assets, net (Note 3)	8,043	10,236
TOTAL ASSETS	$ 304,380	11,136
LIABILITIES AND STOCKHOLDER'S DEFICIT		
Liabilities:		
Accounts payable and accrued liabilities	$ 147,701	72,205
Note payable, affiliate (Note 5)	305,000	-
Due to affiliated organizations, net (Note 5)	46,607	169,914
TOTAL LIABILITIES	499,308	242,119
Stockholder's Deficit:		
Common stock, $1.00 par value; Authorized, issued and outstanding 1,000 shares	1,000	1,000
Additional paid-in capital (Note 7)	500,000	-
Deficit accumulated during the development stage (Note 1)	(695,928)	(231,983)
TOTAL STOCKHOLDER'S DEFICIT	(194,928)	(230,983)
TOTAL LIABILITIES AND STOCKHOLDER'S DEFICIT	$ 304,380	11,136

See accompanying notes to financial statements.

ADA Financial Services Company, Inc.

(A development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Operations and Accumulated Deficit

	Year Ended December 31, 1995	Period from August 4, 1994 to December 31, 1994	Period from August 4, 1994 to December 31, 1995
REVENUES			
Royalties and service fees	$ 20,581	-	20,581
EXPENSES			
Staff compensation, taxes and benefits (Note 5)	131,049	-	131,049
Endorsement costs (Note 6)	281,096	-	281,096
Professional services	199,224	285,322	484,546
Facility and utility costs	14,912	-	14,912
Office expense	11,773	513	12,286
Printing and project expenses	6,025	-	6,025
Meeting and travel expenses	48,274	32,891	81,165
Depreciation and amortization	2,957	731	3,688
Interest expense (Note 5)	10,675	-	10,675
Other expenses, including allocated general and administrative expenses (Note 5)	70,477	74,944	145,421
TOTAL EXPENSES	776,462	394,401	1,170,863
Loss before income taxes	(755,881)	(394,401)	(1,150,282)
Income tax benefit (Note 4)	291,936	162,418	454,354
Net loss	(463,945)	(231,983)	(695,928)
Deficit accumulated at beginning of period	(231,983)	-	-
Deficit accumulated at end of period	$ (695,928)	(231,983)	(695,928)

See accompanying notes to financial statements.

ADA Financial Services Company, Inc.

(A development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Cash Flows

	Year Ended December 31, 1995	Period from August 4, 1994 to December 31, 1994	Period from August 4, 1994 to December 31, 1995
CASH FLOWS FROM OPERATING ACTIVITIES			
Net loss	$ (463,945)	(231,983)	(695,928)
Adjustments to reconcile net loss to net cash used by operating activities:			
Depreciation and amortization	2,957	731	3,688
Deferred income taxes	10,459	(157,722)	(147,263)
Changes in assets and liabilities:			
Receivables	(7,655)	-	(7,655)
Due to affiliated organizations, net	(133,766)	327,636	193,870
Accounts payable and accrued liabilities	75,496	72,205	147,701
Net cash (used) provided by operating activities	(516,454)	10,867	(505,587)
NET CASH USED BY INVESTING ACTIVITIES			
Organization costs incurred	-	(10,967)	(10,967)
Acquisitions of furniture and equipment	(8,314)	-	(8,314)
Net cash used by investing activities	(8,314)	(10,967)	(19,281)
CASH FLOWS FROM FINANCING ACTIVITIES			
Proceeds from note payable, affiliate	305,000	-	305,000
Proceeds from additional capital contribution	500,000	-	500,000
Sale of common stock	-	1,000	1,000
Net cash provided by financing activities	805,000	1,000	806,000
Net increase in cash	280,232	900	281,132
Cash at beginning of period	900	-	-
Cash at end of period	$ 281,132	900	281,132

See accompanying notes to financial statements.

ADA Financial Services Company, Inc.

(A development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: ADA Financial Services Company, Inc. (FINCO) is a development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc. (ADAHC), which in turn is a wholly-owned subsidiary of the American Dental Association (Association). FINCO was established on August 4, 1994 as a for-profit corporation to offer a range of financial services to Association members.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten years, the estimated useful lives of the assets.

Other Assets: Organization costs incurred in the establishment of the corporation have been capitalized and are being amortized on the straight-line method over a 60-month period.

Endorsement Costs: Endorsement costs are recognized when conditions for their accrual under the agreements with participating state societies or their subsidiaries are satisfied.

Income Taxes: Deferred taxes are provided for temporary differences between the financial reporting basis and the tax basis of assets and liabilities. Deferred taxes are based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

Development Stage Activities: During the development stage FINCO has been engaged in assessing the market for its financial services, acquiring a financial services partner, marketing its financial services program to dental societies across the country and developing promotional materials to market its services to the ultimate consumers.

2. Furniture and Equipment

Furniture and equipment at December 31, 1995 and 1994 consisted of the following:

		1995	1994
Furniture and equipment	$	8,314	-
Less accumulated depreciation		764	-
	$	7,550	-

3. Other Assets

Other assets at December 31, 1995 and 1994 consisted of the following:

		1995	1994
Organization costs	$	10,967	10,967
Less accumulated amortization		2,924	731
	$	8,043	10,236

ADA Financial Services Company, Inc.

(A development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

4. Income Taxes

FINCO's operating results are included in the consolidated income tax returns of ADAHC. Income taxes for financial reporting purposes are calculated as if FINCO filed its own income tax returns.

Income taxes benefits for the periods ended December 31, 1995 and 1994 are as follows:

	1995	1994
Current:		
Federal	$ (246,325)	(3,806)
State	(56,070)	(890)
Current income tax benefit	(302,395)	(4,696)
Deferred:		
Federal	8,610	(129,844)
State	1,849	(27,878)
Deferred income taxes (benefits)	10,459	(157,722)
Net income tax benefit	$ (291,936)	(162,418)

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense, for the periods ended December 31, 1995 and 1994, by the provision for state income taxes.

Net deferred tax assets amounting to $147,263 and $157,722 at December 31, 1995 and 1994, respectively, are reflected on the consolidated financial statements of ADAHC (Note 5). Deferred tax assets of $147,635 and $157,722 as of December 31, 1995 and 1994, respectively, result from differences in the book basis and the tax basis of "start-up" expenses. "Start-up" expenses represent operating costs of FINCO incurred prior to commencing substantial business operations. Under tax law these expenses will be amortized using the straight-line method over a 60-month period following commencement of substantial business operations. Deferred tax liabilities of $372 and $0 as of December 31, 1995 and 1994, respectively, result from differences between the book basis and the tax basis of furniture and equipment.

5. Transactions With Related Parties

The Association and ADAHC provide FINCO with administrative services as may be required. The allocated cost of such services amounted to $78,613 and $74,844 during the periods ended December 31, 1995 and 1994, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Included in the allocated expenses described above are pension expense charges associated with FINCO's employees who are participants in the Association's retirement plans. These expenses, which amounted to $9,013 in 1995, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of FINCO.

The Association also leases office space to FINCO. Rent expense under this lease amounted to $13,685 during 1995. The office space lease amounts to $1,369 a month. This lease is on a month-to-month basis.

ADA Financial Services Company, Inc.

(A development stage enterprise and wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

At December 31, 1995 and 1994, amounts due from (to) affiliated organizations were as follows:

	1995	1994
Association	$ (490,462)	(322,607)
ADAHC (includes deferred tax assets - Note 4)	444,669	152,693
ADA Publishing Company, Inc.	(814)	-
	$ (46,607)	(169,914)

On July 1, 1995 the Association loaned FINCO $305,000 in exchange for an unsecured promissory note bearing simple interest at 7% per annum. The note is due July 1, 2000 and can be prepaid, in whole or in part, at any time without penalty. Interest expense amounted to $10,675 for the year ended December 31, 1995.

6. Endorsement Costs

On July 1, 1995 the Association ceased endorsing affinity cards and other financial products offered by Maryland Bank N.A. ("MBNA") in favor of products offered by Mellon Bank and FINCO. During 1995 participating state dental societies or their related financial service subsidiaries entered into agreements with FINCO and the Association. These agreements require the state organizations to endorse FINCO's ADA1PLAN products to its members, in exchange for a share in the revenues generated by the program. The agreements also provide for different service fees or royalties depending upon the specific products involved. In addition, through December 31, 1996, the agreements guarantee participating organizations will receive, at a minimum, what they would have earned in the comparable period of the previous year by continuing to endorse the affinity card program with MBNA. Additionally, a new card fee of $40 is paid for each new affinity card opened in a participating state through December 31, 1996.

Endorsement costs for 1995 are comprised of these adjustment royalties and new card fees.

7. Liquidity

During 1995 and 1994, FINCO sustained significant operating deficits. During 1995, ADAHC made an additional investment of $500,000 to fund FINCO's operations and, as described in Note 5, the Association provided funds to FINCO through an unsecured note. The ability of FINCO to continue operations while in the development stage may require additional advances or contributions from ADAHC and the Association.

Report of Independent Certified Public Accountants

The Board of Directors and Stockholder
ADA Publishing Company, Inc.

We have audited the accompanying balance sheets of ADA Publishing Company, Inc. (a wholly-owned subsidiary of ADA Holding Company, Inc.) as of December 31, 1995 and 1994, and the related statements of income and retained earnings (deficit), and cash flows for the years then ended. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of ADA Publishing Company, Inc. as of December 31, 1995 and 1994 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

ADA Publishing Company, Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Balance Sheets

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash and cash equivalents	$ 530,179	1,103,913
Receivables, net of allowance for doubtful accounts of $60,000 in 1995 and 1994	981,946	898,875
Furniture and equipment, net (Note 2)	292,176	307,505
Prepaid expenses and other assets	167,221	120,947
TOTAL ASSETS	$1,971,522	2,431,240
LIABILITIES AND STOCKHOLDER'S EQUITY		
Liabilities:		
Accounts payable and accrued liabilities	$ 421,870	299,239
Due to affiliated organizations, net (Note 4)	382,083	180,785
Deferred revenues	303,037	321,100
TOTAL LIABILITIES	1,106,990	801,124
Stockholder's Equity:		
Common stock, $10 par value; Authorized, issued and outstanding 100,000 shares	1,000,000	1,000,000
Additional paid-in capital	501,000	501,000
Retained earnings (deficit)	(636,468)	129,116
TOTAL STOCKHOLDER'S EQUITY	864,532	1,630,116
TOTAL LIABILITIES AND STOCKHOLDER'S EQUITY	$1,971,522	2,431,240

See accompanying notes to financial statements.

ADA Publishing Company, Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Income and Retained Earnings (Deficit)

Years Ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Advertising, including classified ads	$7,705,213	7,584,110
Subscriptions	489,200	400,968
Publishing fees (Note 4)	760,000	760,000
Investment income	19,662	30,406
Other income	383,866	343,848
TOTAL REVENUES	9,357,941	9,119,332
EXPENSES		
Staff compensation, taxes and benefits (Note 4)	1,852,049	1,639,534
Publication, printing and project expenses	5,744,602	4,858,214
Professional services	134,574	123,048
Facility and utility costs	215,325	215,137
Office expense	123,685	112,253
Meeting and travel expenses	80,959	63,595
Depreciation	53,621	48,033
Other expenses, including allocated general and administrative expenses (Note 4)	457,501	398,257
TOTAL EXPENSES	8,662,316	7,458,071
Income before income tax expense	695,625	1,661,261
Income tax expense (Note 3)	(261,209)	(654,227)
Net Income	434,416	1,007,034
Retained earnings (deficit) at beginning of year	129,116	(52,918)
Dividends paid	(1,200,000)	(825,000)
Retained earnings (deficit) at end of year	$ (636,468)	129,116

See accompanying notes to financial statements.

ADA Publishing Company, Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Statements of Cash Flows

Years Ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Net income	$ 434,416	1,007,034
Adjustments to reconcile net income to net cash provided by operating activities:		
Depreciation	53,621	48,033
Deferred income taxes	4,719	241,666
Changes in assets and liabilities:		
Receivables, net	(83,071)	21,188
Due to/from affiliated organizations, net	196,579	1,129
Prepaid expenses and other assets	(46,274)	71,853
Accounts payable and accrued liabilities	122,631	(80,387)
Deferred revenues	(18,063)	114,288
Net cash provided by operating activities	664,558	1,424,804
NET CASH USED BY INVESTING ACTIVITIES-		
Acquisitions of furniture and equipment	(38,292)	(64,659)
NET CASH USED BY FINANCING ACTIVITIES-		
Payment of dividends	(1,200,000)	(825,000)
Net (decrease) increase in cash and cash equivalents	(573,734)	535,145
Cash and cash equivalents at beginning of year	1,103,913	568,768
Cash and cash equivalents at end of year	530,179	1,103,913
SUPPLEMENTAL DISCLOSURE OF CASH FLOW INFORMATION		
Cash paid during the year for income taxes, net of tax refunds	$ 267,000	431,750

See accompanying notes to financial statements.

ADA Publishing Company, Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: ADA Publishing Company, Inc. (ADAPCO) is a wholly-owned subsidiary of ADA Holding Company, Inc. (ADAHC), which in turn is a wholly-owned subsidiary of the American Dental Association (Association). ADAPCO is a for-profit corporation whose current business is to perform certain publishing functions for the publications of the Association, including *JADA*, *ADA News* and *Dental Teamwork*.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Cash Equivalents: Cash equivalents at December 31, 1995 and 1994 consist of interest bearing deposits under overnight repurchase agreements, which are carried at their fair value.

Furniture and Equipment: Furniture and equipment are stated at cost less accumulated depreciation. Depreciation is computed on the straight-line method over five to ten years, the estimated useful lives of the assets.

Revenue and Expense Recognition: Subscriptions to periodicals are recognized as revenue over the terms of the subscriptions. Advertising revenue and direct publication costs are recognized in the period the related publication is issued.

Income Taxes: Deferred taxes are established for temporary differences between the financial reporting basis and the tax basis of assets and liabilities, based upon enacted tax rates which would apply during the period in which taxes become payable or recoverable, and the adjustment of cumulative deferred taxes for any changes in the tax rate.

2. Furniture and Equipment

Furniture and equipment at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Furniture and equipment	$ 524,642	486,350
Less accumulated depreciation	232,466	178,845
	$ 292,176	307,505

3. Income Taxes

ADAPCO's operating results are included in the consolidated income tax returns of ADAHC. Income taxes for financial reporting purposes are calculated as if ADAPCO filed its own income tax returns.

ADA Publishing Company, Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

Income tax expense for the years ended December 31, 1995 and 1994 is as follows:

	1995	1994
Current:		
Federal	$ 206,948	298,398
State	49,542	114,163
Current income tax expense	256,490	412,561
Deferred:		
Federal	3,885	236,250
State	834	5,416
Deferred income tax expense	4,719	241,666
Total income tax expense	$ 261,209	654,227

Income tax expense differs from the amount computed by applying the statutory federal income tax rate of 34% to income before income tax expense for the years ended December 31, 1995 and 1994 as follows:

	1995	1994
Statutory federal income tax	$ 236,513	564,829
State income taxes	49,542	114,360
Over provision of prior year taxes	(22,883)	(29,677)
Other, net	(1,963)	4,715
Income tax expense	$ 261,209	654,227

Net deferred tax liabilities approximating $33,000 and $28,000 at December 31, 1995 and 1994, respectively, are reflected on the consolidated financial statements of ADAHC (Note 4). Deferred tax assets approximating $46,900 at December 31, 1995 and 1994 result primarily from the availability of alternative minimum tax credits, and differences in the book basis and the tax basis of receivables. Deferred tax liabilities approximating $79,900 and $74,900 at December 31, 1995 and 1994, respectively, result from differences between the book basis and the tax basis of furniture and equipment.

During the year ended December 31, 1994, ADAPCO realized a benefit of $121,735 resulting from the use of net operating loss carryforwards generated in prior years. At December 31, 1994, ADAPCO had no remaining net operating loss carryforwards.

4. Transactions With Related Parties

The Association and ADAHC provide ADAPCO with administrative services as may be required. The allocated cost of such services amounted to $549,459 and $481,314 during the years ended December 31, 1995 and 1994, respectively.

The Association sponsors a noncontributory defined benefit pension plan and a savings and retirement plan which cover substantially all employees of the Association and its subsidiaries meeting certain eligibility requirements. Included in the allocated expenses described above are pension expense charges associated with ADAPCO's employees who are participants in the Association's retirement plans. These expenses, which amounted to $129,700 and $128,865 in 1995 and 1994, respectively, are based upon the actual cash contributions made by the Association to the plans for the benefit of employees of ADAPCO.

ADA Publishing Company, Inc.

(A wholly-owned subsidiary of ADA Holding Company, Inc.)

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

In addition, during 1995 the Association and its Subsidiaries adopted Statement of Financial Accounting Standards No. 106, "Employer's Accounting for Postretirement Benefits other than Pensions". Included in the allocated expenses described above are post retirement benefit charges of $14,655 associated with participating ADAPCO employees. The effect of adopting this Standard was not significant.

The Association also leases equipment and office space to ADAPCO. Rent expense under these leases amounted to $217,317 and $217,129 during 1995 and 1994, respectively. The office space lease amounts to $16,612 a month. This lease is on a month-to-month basis. Minimum future rentals to be paid for equipment leased under non-cancelable operating leases currently in effect are $15,000 for each year through 1999.

At December 31, 1995 and 1994, amounts due from (to) affiliated organizations were as follows:

	1995	1994
Association	$ (167,140)	41,692
ADAHC (includes deferred tax liabilities, net - Note 3)	(216,686)	(222,477)
ADA Financial Services Co.	814	-
American Dental Association Health Foundation	929	-
	$ (382,083)	(180,785)

Effective January 1, 1990, the Association and ADA Publishers, Inc., a predecessor corporation to ADAPCO, entered into a publishing agreement which has been assigned to ADAPCO. The term of the agreement is five years with an option for automatic renewal for an additional five years, unless terminated by the parties pursuant to terms of the agreement. Under the terms of the agreement, ADAPCO performs all publishing and distribution functions related to the Association's three major publications, and may include new publications developed in the future. In connection with the agreement, the Association assigned all relevant production and advertising contracts, together with all nonmember subscriptions and the revenue from single copy sales, to ADAPCO. Under the terms of the agreement, the Association paid publishing fees to ADAPCO in the amount of $760,000 during the years ended December 31, 1995 and 1994. Also under the terms of the agreement, ADAPCO paid a royalty fee to the Association for the use of Association trademarks in connection with its publishing activity. The royalty is payable at a rate of 2% of ADAPCO's pre-tax income. Royalties paid were approximately $14,200 and $34,000 for 1995 and 1994, respectively.

Report of Independent Certified Public Accountants

Commission on Relief Fund Activities
American Dental Association

We have audited the accompanying statements of financial position of American Dental Association Relief Fund (Relief Fund) as of December 31, 1995 and 1994, and the related statements of activities, functional expenses and cash flows for the years then ended. These financial statements are the responsibility of the Relief Fund's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of American Dental Association Relief Fund as of December 31, 1995 and 1994, and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

As discussed in Note 1 to the financial statements, in 1995 the Relief Fund adopted the provisions of Statement of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made" and 117, "Financial Statements of Not-for-Profit Organizations".

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

American Dental Association Relief Fund

Statements of Financial Position

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash	$ -	39,090
Interest and dividends receivable	18,553	28,550
Grants due from constituent societies	42,471	16,021
Due from affiliates (Note 4)	10,886	12,139
Marketable securities, at market (Note 2)	5,656,548	5,645,454
Furniture and equipment, net (Note 3)	13,977	19,966
TOTAL ASSETS	$5,742,435	5,761,220
LIABILITIES AND NET ASSETS		
Accounts payable	$ 48,155	1,121
Due to constituent societies	470,225	627,284
TOTAL LIABILITIES	518,380	628,405
Net assets	5,224,055	5,132,815
TOTAL LIABILITIES AND NET ASSETS	$5,742,435	5,761,220

See accompanying notes to financial statements.

American Dental Association Relief Fund

Statements of Activities

Years ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Contributions	$ 313,470	480,550
Allocation of contributions to constituent societies	(259,496)	(384,237)
Net contributions	53,974	96,313
Earnings (loss) on investments:		
Interest and dividends	243,020	199,468
Net realized capital gains (losses)	436,107	(95,635)
Net unrealized depreciation of marketable securities	(6,968)	(497,987)
Investment management fees and expenses	(54,981)	(40,214)
Net earnings (loss) on investments	617,178	(434,368)
Miscellaneous income	-	730
TOTAL REVENUES	671,152	(337,325)
EXPENSES		
Program services	325,198	453,532
General and administrative	180,406	171,872
Fundraising	74,308	63,683
TOTAL EXPENSES	579,912	689,087
Increase (decrease) in net assets	91,240	(1,026,412)
Net assets at beginning of year (Note 1)	5,132,815	6,159,227
Net assets at end of year	$5,224,055	5,132,815

See accompanying notes to financial statements.

American Dental Association Relief Fund

Statements of Functional Expenses

Years Ended December 31, 1995 and 1994

	1995				1994			
	Program Services	Supporting Services			Program Services	Supporting Services		
	Grants	General and Administrative	Fundraising	Total	Grants	General and Administrative	Fundraising	Total
EXPENSES								
Relief Grants	$ 325,198	-	-	325,198	339,274	-	-	339,274
Grant to The ADA Emergency Fund, Inc.	-	-	-	-	90,000	-	-	90,000
Grant to constituent dental Society	-	-	-	-	24,258	-	-	24,258
Staff compensation, taxes and benefits	-	108,843	-	108,843	-	100,623	-	100,623
Travel	-	15,401	-	15,401	-	18,611	-	18,611
Telephone	-	5,508	-	5,508	-	4,642	-	4,642
Office supplies	-	3,971	3,209	7,180	-	4,922	-	4,922
Postage and mailing	-	2,803	34,672	37,475	-	3,770	42,897	46,667
Printing and artwork	-	2,341	36,427	38,768	-	1,519	20,786	22,305
Professional services	-	35,550	-	35,550	-	32,018	-	32,018
Depreciation	-	5,989	-	5,989	-	5,767	-	5,767
TOTAL EXPENSES	$ 325,198	180,406	74,308	579,912	453,532	171,872	63,683	689,087

See accompanying notes to financial statements.

American Dental Association Relief Fund

Statements of Cash Flows

Years ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Increase (decrease) in net assets	$ 91,240	(1,026,412)
Adjustments to reconcile increase (decrease) in net assets to net cash used by operating activities:		
Depreciation	5,989	5,767
Net realized capital (gains) losses	(436,107)	95,635
Net unrealized depreciation of marketable securities	6,968	497,987
Changes in assets and liabilities:		
Interest and dividends receivable	9,997	9,839
Grants due from constituent societies	(26,450)	23,587
Due from affiliates	1,253	(12,139)
Accounts payable	47,034	(98,702)
Due to affiliates	-	(21,963)
Due to constituent societies	(157,059)	94,578
Net cash used by operating activities	(457,135)	(431,823)
CASH FLOWS FROM INVESTING ACTIVITIES		
Purchase of marketable securities	(13,255,884)	(7,083,870)
Sale and maturity of marketable securities	13,673,929	7,556,462
Acquisition of equipment	-	(2,226)
Net cash provided by investing activities	418,045	470,366
Net (decrease) increase in cash	(39,090)	38,543
Cash at beginning of year	39,090	547
Cash at end of year	$ -	39,090

See accompanying notes to financial statements.

American Dental Association Relief Fund

Notes to Financial Statements, December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: The American Dental Association Relief Fund (Relief Fund) was established by the American Dental Association (ADA) under the terms of an Indenture of Trust (Relief Trust) executed September 30, 1948. The Relief Fund renders financial aid to members of the dental profession and their dependents who, because of misfortune, age or other disabling conditions, are not wholly self-sustaining. The Commission on Relief Fund Activities (Commission), elected from the ADA membership, is the trustee for the Relief Fund.

The Relief Trust may be amended or terminated by action of the ADA. Upon termination, the Trust properties shall revert to the ADA to be used exclusively for charitable purposes.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Marketable Securities: Investments in marketable securities are carried at fair value. The fair value of the marketable securities is estimated based on quotes from brokers or current rates offered for instruments with similar characteristics.

Revenue Recognition: All income from investments is recognized on the accrual basis. Contributions, which are received from the ADA membership directly and through constituent societies, are recognized when pledged or received.

Allocation of Relief Fund Contributions: The rules of the Relief Fund provide that refunds of contributions may be made to constituent societies if those societies have been established as charitable organizations having purposes consistent with those of the Relief Fund, and have been accorded tax-exempt status under the Internal Revenue Code. Prior to payment of any refund, constituent society relief funds are also required to submit annual financial statements. Such financial statements are required to be audited by a certified public accountant at least once every five years. For any constituent dental society relief fund whose average fund balance over the past five (5) years is below $50,000, a substitute statement for the required five (5) year audit is permissible, if signed and certified by at least two officials of the constituent society relief fund. Refunds in the amount of $343,472 and $466,272 at December 31, 1995 and 1994, respectively (from prior years' Relief Fund contributions), are payable to societies whose relief funds have not yet qualified for payment under the rules of the Relief Fund. As of December 31, 1995, $126,753 has been reserved for the fiscal year 1996 campaign which ends June 30, 1996.

Grant Expense: Grants to relief recipients are recorded when the grant is paid. Obligations for future grant payments previously authorized by the Commission amounted to $90,845 and $117,154 at December 31, 1995 and 1994, respectively. Grants paid are usually shared equally by the Relief Fund and the recipient's constituent society.

Functional Expenses: The statement of functional expenses reflects direct costs related to general and administrative and fundraising activities.

Adoption of Accounting Standards: In 1995, the Relief Fund adopted the provisions of Statement of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made", and 117, "Financial Statements of Not-for-Profit Organizations". In accordance with the Standards, all not-for-profit organizations are required to classify contributions and net assets based on the existence or absence of donor-imposed restrictions. Net assets subject to donor-imposed stipulations are to be classified as temporarily restricted net assets, while net assets not subject to such restrictions are to be classified as unrestricted net assets. As any restrictions on contributions to the Relief Fund are satisfied immediately, unrestricted net assets are presented using one classification. The Relief Fund is also required to present statements of financial position, activities, functional expenses, and cash flows in accordance with the provisions of the Standards. As a result of adopting the new accounting standards, the 1994 financial statements have been restated to conform to the 1995 presentation. There was no effect on the 1994 net asset balance as a result of the restatement.

American Dental Association Relief Fund

Notes to Financial Statements, December 31, 1995 and 1994 (continued)

2. Marketable Securities

Marketable securities as of December 31, 1995 and 1994 consisted of the following:

	1995		1994	
	Cost	Market	Cost	Market
Commercial paper	$ 116,235	116,235	310,289	310,289
Corporate bonds	465,470	486,520	407,489	408,060
U.S. government obligations	1,096,414	1,102,891	1,217,430	1,232,556
Common stocks	3,694,666	3,950,902	3,419,515	3,694,549
Total	$5,372,785	5,656,548	5,354,723	5,645,454

3. Furniture and Equipment

Furniture and equipment at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Furniture and equipment	$ 29,946	29,946
Less accumulated depreciation	15,969	9,980
	$ 13,977	19,966

4. Related Party Transactions

The ADA provides administrative and financial support to the Relief Fund. General and administrative expenses include allocations from the ADA. The allocated cost of such services amounted to $15,600 and $14,600 during the years ended December 31, 1995 and 1994, respectively.

At December 31, 1995 and 1994, amounts due from affiliates were as follows:

	1995	1994
American Dental Association	$ 9,782	11,839
The ADA Endowment and Assistance Fund, Inc.	1,104	100
The ADA Emergency Fund, Inc.	-	200
	$ 10,886	12,139

5. Income Taxes

The Relief Fund qualifies under section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes on income related to its exempt purpose under section 501(a) of the Code. The Relief Fund had no significant unrelated business income during 1995 and 1994.

Report of Independent Certified Public Accountants

Board of Directors
The ADA Endowment and Assistance Fund, Inc.

We have audited the accompanying statements of financial position of the ADA Endowment and Assistance Fund, Inc. (Endowment Fund) as of December 31, 1995 and 1994, and the related statements of activities and cash flows for the years then ended. These financial statements are the responsibility of the Endowment Fund's management. Our responsibility is to express an opinion on these financial statements based on our audits.

We conducted our audits in accordance with generally accepted auditing standards. Those standards require that we plan and perform the audit to obtain reasonable assurance about whether the financial statements are free of material misstatement. An audit includes examining, on a test basis, evidence supporting the amounts and disclosures in the financial statements. An audit also includes assessing the accounting principles used and significant estimates made by management, as well as evaluating the overall financial statement presentation. We believe that our audits provide a reasonable basis for our opinion.

In our opinion, the financial statements referred to above present fairly, in all material respects, the financial position of the ADA Endowment and Assistance Fund, Inc. as of December 31, 1995 and 1994 and the results of its operations and its cash flows for the years then ended in conformity with generally accepted accounting principles.

As discussed in Note 1 to the financial statements, in 1995 the Endowment Fund adopted the provisions of Statement of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made" and 117, "Financial Statements of Not-for-Profit Organizations".

Grant Thornton LLP

GRANT THORNTON LLP

Chicago, Illinois
March 29, 1996

The ADA Endowment and Assistance Fund, Inc.

Statements of Financial Position

December 31, 1995 and 1994

	1995	1994
ASSETS		
Cash	$ 12,955	18,864
Interest receivable	7,625	11,312
Due from affiliates (Note 4)	-	640
Loans receivable, net (Note 5)	244,702	345,137
Marketable securities, at market (Note 2)	1,593,238	1,443,213
Furniture and equipment, net (Note 3)	1,558	2,003
TOTAL ASSETS	$1,860,078	1,821,169
LIABILITIES AND NET ASSETS		
Accounts payable	$ 2,326	2,381
Due to affiliates (Note 4)	47,572	-
TOTAL LIABILITIES	49,898	2,381
Net Assets	1,810,180	1,818,788
TOTAL LIABILITIES AND NET ASSETS	$1,860,078	1,821,169

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Statements of Activities

Years ended December 31, 1995 and 1994

	1995	1994
REVENUES		
Earnings (loss) on investments:		
Interest and dividends	$ 85,143	83,838
Net realized capital gains (losses)	58,025	(12,403)
Net unrealized appreciation (depreciation) of marketable securities	50,027	(95,493)
Investment management fees and expenses	(17,493)	(10,357)
Net earnings (loss) on investments	175,702	(34,415)
Scholarship contributions	43,000	35,520
Interest on loans	2,944	6,111
Miscellaneous income	-	100
TOTAL REVENUES	221,646	7,316
EXPENSES		
Dental Student Scholarship Awards	51,250	58,750
Dental Hygienist Scholarship Awards	18,000	23,000
Laboratory Technical Scholarship Awards	12,500	16,500
Dental Assistant Scholarship Awards	18,500	25,000
Minority Dental Student Scholarship Awards	33,000	31,000
General and administrative	74,990	67,183
Uncollectible loans expense	21,569	4,500
Depreciation	445	223
TOTAL EXPENSES	230,254	226,156
Decrease in net assets	(8,608)	(218,840)
Net assets at beginning of year (Note 1)	1,818,788	2,037,628
Net assets at end of year	$1,810,180	1,818,788

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Statements of Cash Flows

Years ended December 31, 1995 and 1994

	1995	1994
CASH FLOWS FROM OPERATING ACTIVITIES		
Decrease in net assets	$ (8,608)	(218,840)
Adjustments to reconcile decrease in net assets to net cash used by operating activities:		
Provision for uncollectible loans receivable	-	4,500
Depreciation	445	223
Net realized capital (gains) losses	(58,025)	12,403
Net unrealized (appreciation) depreciation of marketable securities	(50,027)	95,493
Changes in assets and liabilities:		
Due from affiliates	640	(640)
Interest receivable	3,687	1,798
Accounts payable	(55)	(5,955)
Due to affiliates	47,572	(3,323)
Net cash used by operating activities	(64,371)	(114,341)
CASH FLOWS FROM INVESTING ACTIVITIES		
Disbursements of loans receivable	(13,500)	(172,750)
Proceeds from loans receivable	113,935	92,554
Purchase of marketable securities	(2,997,525)	(1,528,949)
Sale and maturity of marketable securities	2,955,552	1,735,933
Acquisition of equipment	-	(2,226)
Net cash provided by investing activities	58,462	124,562
Net (decrease) increase in cash	(5,909)	10,221
Cash at beginning of year	18,864	8,643
Cash at end of year	$ 12,955	18,864

See accompanying notes to financial statements.

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements

December 31, 1995 and 1994

1. Significant Accounting Policies

Basis of Presentation: The ADA Endowment and Assistance Fund, Inc. (Endowment Fund) was established by a transfer of properties from the Disaster Trust of the American Dental Association Disaster Victims Emergency Loan Fund (Disaster Fund) on December 31, 1989, at which time the Disaster Fund was terminated. The Members of the Commission on Relief Fund Activities, elected from the membership of the American Dental Association (ADA), serve as Directors for the Endowment Fund. The Endowment Fund was organized for charitable and educational purposes, which include providing emergency assistance in the form of interest-free loans to dentists who were victims of natural disasters and whose resources had been seriously depleted, and other loans or grants for charitable purposes.

Use of Estimates: In preparing financial statements in conformity with generally accepted accounting principles, management is required to make estimates and assumptions that affect the reported amounts of assets and liabilities, the disclosure of contingent assets and liabilities at the date of the financial statements, and the reported amounts of revenues, expenses, gains and losses during the reporting period. Actual results could differ from those estimates.

Fair Value of Financial Instruments: The Endowment Fund's financial instruments include marketable securities and loans receivable. The fair value of investments in marketable securities is estimated based on quotes from brokers or current rates offered for instruments with similar characteristics. The carrying value of loans receivable approximates their estimated fair values based upon management's best estimate.

Marketable Securities: Investments in marketable securities are carried at fair value.

Revenue Recognition: Interest income from loans is recognized when received which is not materially different from recognition on the accrual basis.

Adoption of Accounting Standards: In 1995, the Endowment Fund adopted the provisions of Statements of Financial Accounting Standards Nos. 116, "Accounting for Contributions Received and Contributions Made", and 117, "Financial Statements of Not-for-Profit Organizations". In accordance with the Standards, all not-for-profit organizations are required to classify contributions and net assets based on the existence or absence of donor-imposed restrictions. Net assets subject to donor-imposed stipulations are to be classified as temporarily restricted net assets, while net assets not subject to such restrictions are to be classified as unrestricted net assets. As any restrictions on contributions to the Endowment Fund are satisfied immediately, unrestricted net assets are presented using one classification. The Endowment Fund is also required to present statements of financial position, activities and cash flows in accordance with the provisions of the Standards. As a result of adopting the new accounting standards, the 1994 financial statements have been restated to conform to the 1995 presentation. There was no effect on the 1994 net asset balance as a result of the restatement.

2. Marketable Securities

Marketable securities at December 31, 1995 and 1994 consisted of the following:

	1995		1994	
	Cost	Market	Cost	Market
Commercial paper	$ 44,176	44,176	377,454	377,454
U.S. government obligations	773,022	801,867	604,254	602,475
Corporate bonds	246,541	249,195	204,990	202,015
Common stocks	458,550	498,000	235,593	261,269
	$ 1,522,289	1,593,238	1,422,291	1,443,213

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements (Continued)

December 31, 1995 and 1994

3. Furniture and Equipment

Furniture and equipment at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Furniture and equipment	$ 2,226	2,226
Less accumulated depreciation	668	223
	$ 1,558	2,003

4. Related Party Transactions

The ADA provides administrative and financial support to the Endowment Fund. General and administrative expenses include allocations from the ADA. The allocated cost of such services amounted to $9,400 and $8,400 during the years ended December 31, 1995 and 1994, respectively.

At December 31, 1995 and 1994, amounts due (to) from affiliates were as follows:

	1995	1994
American Dental Association	$ (46,468)	740
American Dental Association Relief Fund	(1,104)	(100)
	$ (47,572)	640

5. Loans Receivable

Loans receivable consist of non-interest bearing loans to disaster victims, loans to assist in the treatment of chemically dependent dentists and loans for educational retraining. Interest, however, is payable on any amounts outstanding after loan maturity. Annual interest rates are 6% on loans granted prior to April 1, 1980, 10% on loans granted between April 1, 1980 and March 31, 1981, 12% on loans granted between April 1, 1981 and December 31, 1991, and 1% over the prime rate on loans granted after December 31, 1991. During 1995 $21,569 of loans were determined to be impaired and were written off. At December 31, 1995 no outstanding loans receivable were deemed to be impaired. Aggregate total maturities of loans receivable for the years ended December 31, 1996 and 1997 are $130,202 and $114,500, respectively.

Loans receivable at December 31, 1995 and 1994 consisted of the following:

	1995	1994
Disaster loans	$ 207,452	306,818
Chemical dependency loans	27,250	32,819
Educational retraining loans	10,000	10,000
	244,702	349,637
Less allowance for uncollectible loans	-	4,500
	$ 244,702	345,137

The ADA Endowment and Assistance Fund, Inc.

Notes to Financial Statements (Continued)

December 31, 1995 and 1994

6. Income Taxes

The Endowment Fund qualifies under Section 501(c)(3) of the Internal Revenue Code (Code) and, therefore, is exempt from Federal income taxes on income related to its exempt purpose under Section 501(a) of the Code. The Endowment Fund had no significant unrelated business income during 1995 and 1994.

American Dental Association

Supplemental Financial Information for the Year Ended December 31, 1995 (Unaudited)

	1995 ACTUAL	1995 BUDGET
NATURAL ACCOUNTS		
REVENUES		
Membership Dues	$ 29,457,371	29,329,600
Rental Income	5,462,104	5,486,200
Sales Income	5,412,082	4,159,500
Testing Fee Income	3,296,271	2,946,300
Grants and Contributions	406,113	260,900
Registration Income	879,985	811,300
Investment Income	555,401	300,000
Miscellaneous Income	5,055,761	6,387,400
TOTAL REVENUES	50,525,088	49,681,200
EXPENSES		
Staff Compensation	22,101,360	24,362,142
Meeting/Travel Expenses	5,420,673	6,133,600
Facility and Utility Costs	3,081,262	3,803,000
Office Expenses	2,468,554	2,879,700
Professional Services	4,680,314	4,601,700
Publication and Project Costs	5,579,213	6,258,900
Grants—Related Health Groups	2,170,435	2,291,000
Depreciation and Amortization	827,207	750,000
Other Expense	1,546,599	1,210,158
TOTAL EXPENSES	47,875,617	52,290,200
NET REVENUE/(EXPENSE) BEFORE INCOME TAXES	2,649,471	(2,609,000)
Income Taxes	24,954	20,000
NET REVENUE/(EXPENSE) AFTER INCOME TAXES	2,624,517	(2,629,000)
Funded Depreciation	(1,000,000)	(1,000,000)
Dividends	700,000	825,000
ADREC Cash Flow Loss	(335,580)	-
Deferral of ADREC Capital Expenditures	(272,939)	-
Pension Funding	(389,885)	-
ADA Online 2000	(521,824)	-
Grassroots Activities	(195,500)	-
Ohio/Alabama Litigation	(17,877)	-
Due from Reserves:		
Grassroots Activities	195,500	195,500
Ohio/Alabama Litigation	17,877	-
NET REVENUE/(EXPENSE)	$ 804,289	(2,608,500)

Divisional Summary Worksheets

House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Miscellaneous Income	$ 837	21,500
TOTAL REVENUES	837	21,500
EXPENSES		
Staff Compensation	1,449,009	1,641,800
Meeting/Travel Expenses	824,442	1,072,500
Office Expenses	201,232	292,800
Professional Services	798,603	899,500
Publication and Project Costs	136,370	195,000
Other Expenses	170,713	188,600
TOTAL EXPENSES	3,580,369	4,290,200
NET REVENUE/(EXPENSE)	$(3,579,532)	(4,268,700)

Division of Legal Affairs

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Miscellaneous Income	$ 38,514	19,600
TOTAL REVENUES	38,514	19,600
EXPENSES		
Staff Compensation	1,082,949	1,213,900
Meeting/Travel Expenses	60,652	77,400
Office Expenses	27,049	28,200
Professional Services	732,261	553,100
Publication and Project Costs	24,159	38,200
Other Expenses	23,580	22,200
TOTAL EXPENSES	1,950,650	1,933,000
NET REVENUE/(EXPENSE)	$(1,912,136)	(1,913,400)

Divisional Summary Worksheets

Division of Government Affairs

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Registration Income	$ 8,265	5,700
TOTAL REVENUES	8,265	5,700
EXPENSES		
Staff Compensation	1,923,241	1,913,800
Meeting/Travel Expenses	448,878	513,200
Facility and Utility Costs	9,999	12,000
Office Expenses	146,918	139,800
Professional Services	111,817	171,000
Publication and Project Costs	59,531	60,000
Other Expenses	48,539	66,800
TOTAL EXPENSES	2,748,923	2,876,600
NET REVENUE/(EXPENSE)	$(2,740,658)	(2,870,900)

Division of Communications

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Registration Income	$ 19,000	21,600
TOTAL REVENUES	19,000	21,600
EXPENSES		
Staff Compensation	1,177,238	1,252,300
Meeting/Travel Expenses	97,776	148,400
Office Expenses	52,392	44,100
Professional Services	273,689	313,200
Publication and Project Costs	713,100	769,000
Other Expenses	10,651	7,400
TOTAL EXPENSES	2,324,846	2,534,400
NET REVENUE/(EXPENSE)	$(2,305,846)	(2,512,800)

Divisional Summary Worksheets

Division of Membership and Dental Society Services

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Grants and Contributions	$ 95,500	82,000
Registration Income	69,470	96,400
Miscellaneous Income	2,531	-
TOTAL REVENUES	167,501	178,400
EXPENSES		
Staff Compensation	2,028,857	2,120,600
Meeting/Travel Expenses	443,789	503,800
Office Expenses	317,550	383,600
Professional Services	118,458	140,300
Publication and Project Costs	410,586	512,800
Other Expenses	15,486	27,900
TOTAL EXPENSES	3,334,726	3,689,000
NET REVENUE/(EXPENSE)	$(3,167,225)	(3,510,600)

Division of Conference and Meeting Services

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Rental Income	$ 3,194,335	3,090,000
Sales Income	113,171	160,000
Grants and Contributions	187,517	100,000
Registration Income	319,369	173,100
Miscellaneous Income	1,218,790	755,800
TOTAL REVENUES	5,033,182	4,278,900
EXPENSES		
Staff Compensation	1,172,959	1,193,500
Meeting/Travel Expenses	1,619,186	1,399,700
Facility and Utility Costs	44,847	62,000
Office Expenses	182,952	198,300
Professional Services	791,545	551,600
Publication and Project Costs	718,571	743,300
Other Expenses	60,600	22,800
TOTAL EXPENSES	4,590,660	4,171,200
NET REVENUE/(EXPENSE)	$ 442,522	107,700

Divisional Summary Worksheets

Division of Finance and Operations

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Investment Income	$ 544,726	300,000
Miscellaneous Income	427,649	505,900
TOTAL REVENUES	972,375	805,900
EXPENSES		
Staff Compensation	2,888,389	3,162,600
Meeting/Travel Expenses	63,971	106,500
Office Expenses	124,523	124,300
Professional Services	104,974	183,000
Publication and Project Costs	164,545	209,700
Other Expenses	434,150	382,900
TOTAL EXPENSES	3,780,552	4,169,000
NET REVENUE/(EXPENSE)	$(2,808,177)	(3,363,100)

Headquarters Building

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Rental Income	$ 2,252,769	2,336,500
Miscellaneous Income	32,048	42,000
TOTAL REVENUES	2,284,817	2,378,500
EXPENSES		
Staff Compensation	352,282	380,400
Facility and Utility Costs	3,026,416	3,729,000
Office Expenses	113,813	114,400
Professional Services	47,176	59,600
Publication and Project Costs	16,140	22,500
Other Expenses	28,626	5,100
TOTAL EXPENSES	3,584,453	4,311,000
NET REVENUE/(EXPENSE)	$(1,299,636)	(1,932,500)

Divisional Summary Worksheets

Salable Materials

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Sales Income	$ 5,298,711	3,989,500
Miscellaneous Income	5,704	44,500
TOTAL REVENUES	5,304,415	4,034,000
EXPENSES		
Staff Compensation	696,887	752,300
Meeting/Travel Expenses	52,312	56,900
Office Expenses	103,877	163,600
Professional Services	15,344	12,000
Publication and Project Costs	1,944,450	2,002,100
Other Expenses	129,270	100,200
TOTAL EXPENSES	2,942,140	3,087,100
NET REVENUE/(EXPENSE)	$ 2,362,275	946,900

Survey Center

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Miscellaneous Income	$ 88,642	86,000
TOTAL REVENUES	88,642	86,000
EXPENSES		
Staff Compensation	609,767	883,600
Meeting/Travel Expenses	8,756	14,600
Office Expenses	49,804	58,600
Professional Services	706,526	696,900
Publication and Project Costs	71,338	42,700
Other Expenses	3,604	5,600
TOTAL EXPENSES	1,449,795	1,702,000
NET REVENUE/(EXPENSE)	$(1,361,153)	(1,616,000)

Divisional Summary Worksheets

Central Administration

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Membership Dues	$29,457,371	29,329,600
Rental Income	15,000	-
Investment Income	10,675	-
Miscellaneous Income	2,336,380	3,696,900
TOTAL REVENUES	31,819,426	33,026,500
EXPENSES		
Staff Compensation	987,070	988,642
Meeting/Travel Expenses	65,715	121,300
Office Expenses	449,877	605,900
Professional Services	330,439	413,500
Publication and Project Costs	108,367	152,200
Depreciation and Amortization	827,207	750,000
Other Expenses	348,552	98,258
EXPENSES SUBTOTAL	3,117,227	3,129,800
Income Taxes	24,954	20,000
TOTAL EXPENSES	3,142,181	3,149,800
NET REVENUE/(EXPENSE)	$28,677,245	29,876,700

Information Technology

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Miscellaneous Income	$ 305,048	296,000
TOTAL REVENUES	305,048	296,000
EXPENSES		
Staff Compensation	1,439,248	1,633,600
Meeting/Travel Expenses	15,803	20,700
Office Expenses	356,133	327,000
Professional Services	101,296	35,000
Publication and Project Costs	22,654	4,500
Other Expenses	2,915	2,900
TOTAL EXPENSES	1,938,049	2,023,700
NET REVENUE/(EXPENSE)	$(1,633,001)	(1,727,700)

Divisional Summary Worksheets

Division of Dental Practice

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Rental Income	$ -	59,700
Grants and Contributions	123,096	60,000
Registration Income	379,171	414,500
Miscellaneous Income	2,896	40,000
TOTAL REVENUES	505,163	574,200
EXPENSES		
Staff Compensation	1,889,853	2,087,800
Meeting/Travel Expenses	712,360	917,100
Office Expenses	109,155	130,600
Professional Services	225,756	305,300
Publication and Project Costs	564,146	899,800
Other Expenses	80,558	97,200
TOTAL EXPENSES	3,581,828	4,437,800
NET REVENUE/(EXPENSE)	$(3,076,665)	(3,863,600)

Division of Education and Science

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
EXPENSES		
Staff Compensation	$ 116,647	280,600
Meeting/Travel Expenses	4,109	11,200
Office Expenses	626	4,700
Publication and Project Costs	201	1,500
Other Expenses	6,473	7,900
TOTAL EXPENSES	128,056	305,900
NET REVENUE/(EXPENSE)	$ (128,056)	(305,900)

Divisional Summary Worksheets

Division of Education

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Sales Income	$ 200	10,000
Testing Fee Income	3,296,271	2,946,300
Registration Income	84,710	100,000
Miscellaneous Income	378,482	344,000
TOTAL REVENUES	3,759,663	3,400,300
EXPENSES		
Staff Compensation	3,030,378	3,381,900
Meeting/Travel Expenses	891,336	1,020,100
Office Expenses	173,006	208,100
Professional Services	315,636	261,700
Publication and Project Costs	581,468	583,900
Other Expenses	157,971	150,600
TOTAL EXPENSES	5,149,795	5,606,300
NET REVENUE/(EXPENSE)	$(1,390,132)	(2,206,000)

Division of Science

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Miscellaneous Income	$ 218,240	535,200
TOTAL REVENUES	218,240	535,200
EXPENSES		
Staff Compensation	1,256,586	1,474,800
Meeting/Travel Expenses	111,588	150,200
Office Expenses	59,647	55,700
Professional Services	6,794	6,000
Publication and Project Costs	43,587	21,700
Other Expenses	24,911	23,800
TOTAL EXPENSES	1,503,113	1,732,200
NET REVENUE/(EXPENSE)	$(1,284,873)	(1,197,000)

Divisional Summary Worksheet

ADA Health Foundation

NATURAL ACCOUNTS	1995 ACTUAL	1995 BUDGET
REVENUES		
Grants and Contributions	$ -	18,900
TOTAL REVENUES	-	18,900
EXPENSES		
Grants—Related Health Groups	2,170,435	2,291,000
TOTAL EXPENSES	2,170,435	2,291,000
NET REVENUE/(EXPENSE)	$(2,170,435)	(2,272,100)

1995 Contingent Fund

Board-Approved Allocations Compared with Actual

	Actual Expenses (Net)	Board Approved Allocations
House, Board, Executive Director, Administration and Policy, Quality and Strategic Planning		
Related Dental Organization special committee	$ 5,301	$13,700
Board of Trustees attendance at Managed Care Conference	16,475	23,200
Division of Legal Affairs		
Outside legal support for California Dental Association	117,590	100,000
Preparation of appeal for Federal Trade Commission lawsuit against California Dental Association	35,000	35,000
Division of Government Affairs		
Funding for one-day meeting of Council on Governmental Affairs and Federal Dental Services preceding its February meeting	5,300	5,300
Retain consultants for continuing effort on health and dental benefit-related issues	106,250	150,000
Division of Communications		
Additional costs associated with producing and distributing *The Dental Advocate* newsletter	29,211	29,400
Production and distribution of 16,500 Grassroots information kits for all Action Team leaders	51,222	60,900
Division of Membership and Dental Society Services		
Reduced revenue for Leadership/Management Conference from not charging registration fee to state presidents and presidents-elect	18,800	18,800
Division of Conference and Meeting Services		
Travel and lodging for additional volunteers to serve on the committee for the 1995 annual session in Las Vegas	7,349	15,000
Pre-annual session Board of Trustees meeting in Phoenix	13,000	12,600
Bar code printers for annual session	18,599 (A)	19,100

Note: (A) Funds spent include both expense items as well as capital items.

	Actual Expenses (Net)	Board Approved Allocations
Central Administration		
Executive Parity Plan funding for 1994 and 1995	105,042	105,042
Division of Information Technology		
Copy of CompuServe to each Board of Trustees member	2,955	4,000
Retain consultants for composition of a survey of ADA members (partial cost)	4,826	5,000
Division of Dental Practice		
Dental Economics Advisory Group (DEAG) to evaluate economic model for health and dental benefits	35,850	36,000
Administrative expenses for DEAG	1,686	16,800
Parameters mailing as *JADA* supplement	43,000	43,000
Division of Education		
Special Board Committee to Study IOM Report	2,851	6,200
Presidential Committee for Commission on Dental Accreditation	4,769	6,300
Second Presidential Committee for Commission on Dental Accreditation	6,467	16,100
Division of Scientific Affairs		
Increased participation of the Association in the ISO/TC106 Dentistry Secretariats	8	14,000
One-day planning meeting for Council on Scientific Affairs	4,442	4,900
Continuation of Waste Management Task Force	21,046	39,600
International Symposium on Separation Technologies for Dental and other Health Care Facilities	2,000	2,000
Total Net Expense Allocation for 1995 Contingent Fund	$ 659,039	781,942

Supplemental requests funded from reserves: The Board also authorized the following supplemental requests in 1994 for funding from reserves, rather than the contingent fund, because their actions cross fiscal years. In 1994, $10,000 was expended for the Alabama Dental Association and $14,525 for the Ohio Dental Association. For 1995 the following has been expended:

Alabama Dental Association legal fees	$ -	50,000
Ohio Dental Association legal fees	17,877	50,000
	$ 17,877	100,000

Notes

Appendix

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1995 Resolutions

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