A Proposed Framework for the Canadian Dental Care Plan

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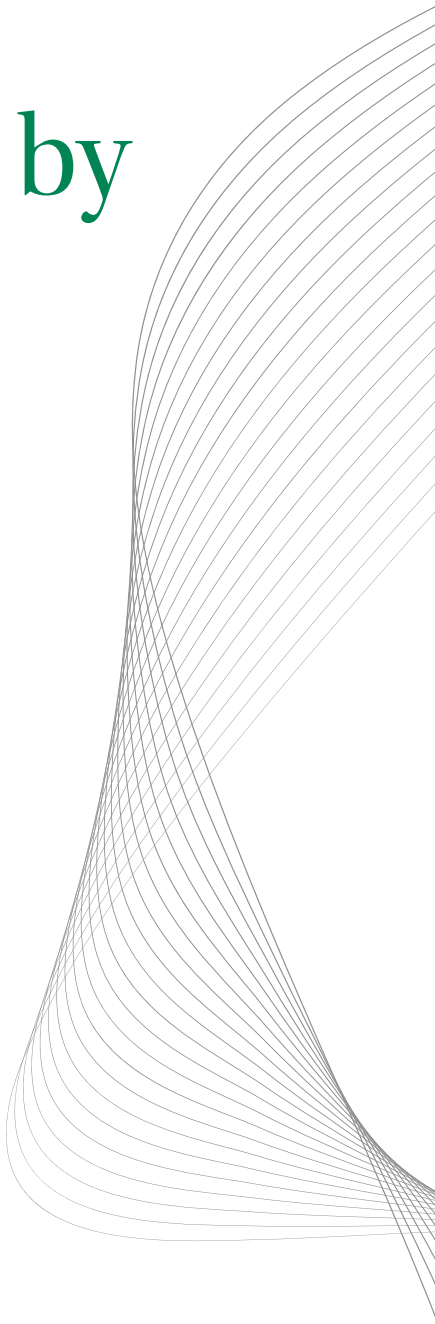
A Technical Submission by the Dentists of Canada

A comprehensive and actionable framework for broad stakeholder support, long-term financial sustainability, optimal patient and provider experience, and improved oral health outcomes for all people in Canada.

November 2023



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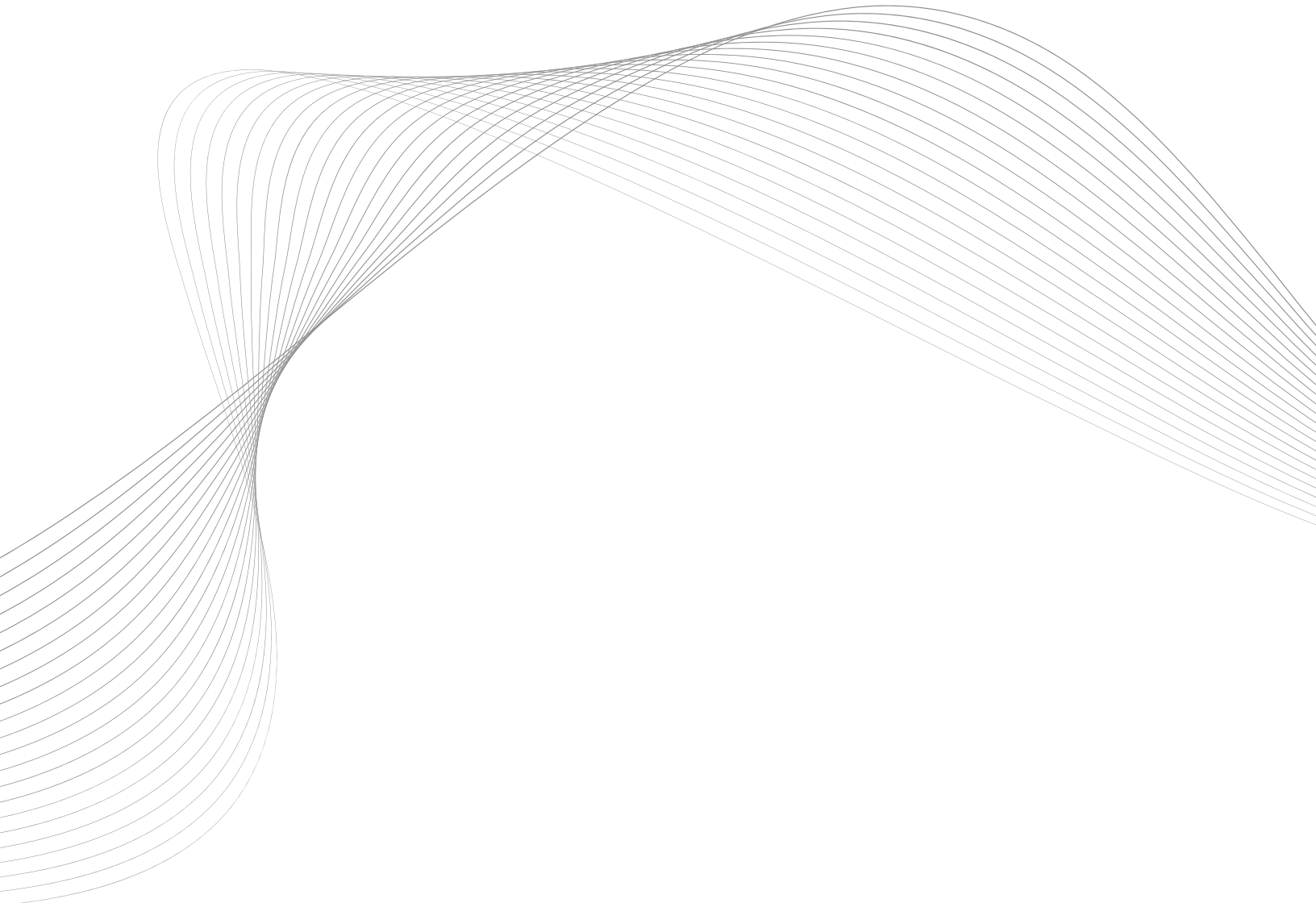


Executive Summary

Dentists of Canada are deeply committed to assisting the Government of Canada in designing, implementing and sustaining a successful and impactful Canadian Dental Care Plan for the benefit of all Canadians. This document provides a comprehensive and actionable framework for the Canadian Dental Care Plan.

Dental Associations across Canada have joined forces to offer an efficient, coordinated "one-stop" resource to Health Canada in their design of the Canadian Dental Care Plan. As Canada's dentists, this is our commitment and obligation to Canadians.

As dedicated providers of oral health care, dentists share a common mission to optimize oral health care in Canada. Canadian families should no longer have to make difficult choices between dental care and other important expenses. In response, Dental Associations moved swiftly to coordinate multi-party data sharing agreements and data management tools in order to model various scenarios against the data to strengthen understanding of the value, costs and constraints of different dental care plan design elements.

Dental Associations have proprietary anonymous and public data sets of statistical information on dental care, including all claims made by dentists to private dental plans across the country (and significant data from dental claims to existing public plans), compiled in a single, searchable database, which is the only database of its kind in Canada.

Along with data considerations, this document considers crucial design elements including:

> **(1) key stakeholders and their leading priorities with respect to achieving a successful plan;**
>
> **(2) how to maintain robust dental care coverage for employees who would otherwise be eligible for the CDCP ("de-insurance risk"); and**
>
> **(3) how provincial fee guides are developed and what they entail.**

This document contains two Annexes.

Annex A presents hypothetical co-pay costing scenarios demonstrating how individuals with household incomes of between $70,000 to $90,000 could be impacted by co-pays with CDCP.

Annex B is a technical report that presents how an oral health spending account could be an effective program solution for the CDCP.

The document is presented as three technical submissions and two Annexes.

Canadian Dental Care Plan Design Options and Data Projections

An important driver of a dental care plan is the level of services covered, or the scope of its coverage. Coverage can be restrictive or extensive and is often determined in relation to different aspects of a plan such as the eligible population or the services provided. The Government of Canada will make relevant policy decisions with respect to coverage of the Canadian Dental Care Plan (CDCP).

To assist with those policy decisions, we have created several possible models for the CDCP coverage design and predicted the estimated costs of each of these designs using the comprehensive database of dentists' historical dental care claims data. Our goal is to assist with the determination of a comprehensive and actionable framework that endears broad stakeholder support, long-term financial sustainability, a dignified user experience, the monitoring of oral diseases and increased financial security and optimal oral health outcomes for Canadian families.

De-Insurance Risk and Budgetary Impact

Many employers and employees will wish to end their provision of, or participation in, employer-sponsored dental care coverage for employees who would be otherwise eligible for the Canadian Dental Care Plan (CDCP). If this risk materialized, the pool of eligible participants for the CDCP, and its cost, could expand *significantly*.

Our key findings are that:

1. Employer-sponsored dental care benefits are a real and direct cost to employers and employees.
2. Many employers and employees will wish to end their provision of/participation in employer-sponsored dental care coverage for employees who otherwise would be eligible for the CDCP.
3. If this risk materialized, the pool of eligible participants for the CDCP, and its cost, could expand *significantly*.
4. Without any mitigation strategies, the potential pool of eligible persons could grow from the estimated 9 million to approximately 17 million.
5. A wait-and-see approach may open the CDCP to criticism of creating unintentional "corporate subsidies" and incentivizing employers to drop private dental coverage for lower-income employees.
6. A set of moderate mitigation steps may reduce the potential pool expansion.

Potential Key Mitigation Strategies Include:

Relationship leverage

Enterprise-wide Benefits Test

Tax or legislative inducements

Supplementation of benefits

Dental Services Fee Guides

1. In Canada, a suggested dental services fee guide is established by the dental association in most provinces and territories and reviewed and analyzed by practicing dentists and independent economists.
2. Fee guides are designed to promote fairness, transparency, confidence and predictability for patients and dentists, while also promoting regionally appropriate pricing, but are not binding to dentists.
3. Fee guides have been shown to promote affordability and accessibility in dental care.
4. Dental care programs that minimize administrative burden and fairly compensate dentists result in improved patient access, higher rates of utilization and an increase in the delivery of preventive care.
5. Many dentists in Canada have busy practices. The CDCP should encourage dentists to participate in the program, make investments in their practices, and accept new patients.
6. Various studies suggest that paying for services in-line with suggested fee guides will encourage dentists to accept new patients, reduce wait-times, increase capacity, and create fairness between public and private patients.
7. It is difficult to draw meaningful comparisons between the Non-Insurance Health Benefits (NIHB) Program and the CDCP. The NIHB is highly tailored to the unique needs and circumstances of First Nations and Inuit peoples, covers a broad set of healthcare services beyond dental services (including pharmacy and transportation), is expensive to deliver and has relatively low utilization.

In Canada, a suggested dental services fee guide is established by the dental association in most provinces and territories. The fee guides are established at least annually and provide a suggested fee or range of fees for dental services that dentists may use as a reference point when setting their own fees. However, the fee guides are not binding on dentists, who are free to charge higher or lower fees.

Suggested fee guides are intended to reflect fees that are based on reasonable and prudent requirements of scientific knowledge, professional judgement and technical skill under normal operating conditions. Each suggested fee is based on a complex formula that seeks to weigh numerous factors and considerations, with specific methodologies that vary between jurisdictions. Fee guides will have an impact on affordability, dentist participation and patient utilization.

An overview of the NIHB program is presented, along with rationale as to why it would not be comparable to CDCP.

Annex A presents hypothetical co-pay costing scenarios demonstrating how individuals with household incomes of between $70,000 to $90,000 could be impacted by co-pays with CDCP.

Annex B is a technical report that presents how an oral health spending account could be an effective program solution for the CDCP.

Introduction to the Framework

According to the World Health Organization's (WHO) global oral health status report 2022, globally close to 3.5 billion people (approximately 50% of the population) suffer from at least one form of oral disease and the global burden of oral diseases exceeds the combined global burden of the next five most prevalent non-communicable diseases by almost a billion cases. Amongst the leading cause of oral health diseases, the report identifies untreated dental caries (both deciduous and permanent teeth), severe periodontal disease, edentulism and cancer of lip and oral cavity as the leading causes of oral disease burden.

This document provides a comprehensive and actionable framework for the Canadian Dental Care Plan (CDCP), through three technical submissions and two annexes:

- **Canadian Dental Care Plan Design Options and Data Projections**
- **De-Insurance Risk and Budgetary Impact**
- **Dental Services Fee Guides**
- **Annex A: Co-Pay Costing Scenarios**
- **Annex B: Oral Health Spending Account as an Effective Program Solution**

This framework is designed to optimize oral healthcare in Canada in a manner that is accessible, equitable, effective, safe, and most importantly, sustainable. Overall health is connected to oral health, and vice versa. Canadian families will no longer be required to make difficult choices between dental care and other important expenses. By considering and balancing the interests of all stakeholders, a plan based on this framework will earn broad support, facilitate implementation and, most importantly, provide meaningful oral healthcare and increased financial security for eligible families.

Purpose and Approach

This document does not focus on the interests of any particular group or stakeholder. Instead, it sets out a comprehensive and actionable framework for the CDCP based on rigorous analysis and a delicate balancing of the important considerations of all stakeholders, including eligible participants, Canadian taxpayers, Finance Canada, Health Canada, the provincial and territorial governments, employers, health insurers, and dental care providers.

In preparing this document, we:

- conducted an extensive review of academic studies and research on the health, social and economic impact of dental and other health plans, both in Canada and beyond;
- engaged, consulted with and obtained specific advice and recommendations from leading industry experts and professional advisors;
- considered views from key stakeholders;
- reviewed and analysed extensive data compiled from dentists in every province and territory of Canada; and
- tested our assumptions through rigorous modelling and projections.

This framework reflects and upholds the intent of the CDCP, including long-term program sustainability, fiscal responsibility, improved access and equity for necessary oral healthcare for underserved populations, and increased financial security for eligible families.

Our Commitment

Dentists of Canada are committed to assisting the Government of Canada in designing, implementing andsustaining a successful and impactful CDCP for the benefit of all Canadians.

Canadian Dental Care Plan

Design Options & Data Projections

Executive Summary

An important driver of a dental care plan is the level of services covered, or the scope of its coverage. Coverage can be restrictive or extensive and is often determined in relation to different aspects of a plan such as the eligible population or the services provided. The Government of Canada will make relevant policy decisions with respect to coverage of the Canadian Dental Care Plan (CDCP).

To assist with those policy decisions, we have created several possible models for the CDCP coverage design and predicted the estimated costs of each of these designs using the comprehensive database of dentists' historical dental care claims data. Our goal is to assist with the determination of a comprehensive and actionable framework that endears broad stakeholder support, long-term financial sustainability, a dignified user experience, the monitoring of oral diseases and increased financial security and optimal oral health outcomes for Canadian families.

Introduction

This chapter can assist in designing an optimal oral healthcare strategy with respect to the CDCP. The Government of Canada has made strong commitments that the CDCP will provide access to dignified, sustainable and impactful dental coverage. Canadian families will no longer be required to make difficult choices between dental care and other important expenses. By considering and balancing the interests of all stakeholders, a plan based on this proposed framework can earn broad support, facilitate implementation and, most importantly, provide necessary oral healthcare and increased financial security for eligible families in a sustainable way.

Purpose and approach

This document sets out our analysis, balancing of the important considerations of all stakeholders, including eligible participants, Canadian taxpayers, Finance Canada, Health Canada, the provincial and territorial governments, employers, health insurers, and oral healthcare providers.

The analysis reflects and upholds the prevailing intent of the CDCP, including long-term program sustainability, fiscal responsibility, improved access and equity for necessary oral healthcare for underserved populations, and increased financial security for eligible families.

The analysis accounts for many compromises and concessions, all made to achieve the prevailing and equal priorities of long-term sustainability, fiscal responsibility and overall success of the plan.

Assumptions

The following assumptions have been made in projecting the number of eligible CDCP participants:

(a) De-insurance risk (see next section) has been mitigated;

(b) Cost is aligned with provincial fee guides for dental services;

(c) Recipient eligibility is determined by the Canada Revenue Agency, not an “opt-in” program;

(d) There are no differentials in costs as between populations for factors such as: transportation, need for restorative versus preventative treatment, and different values/beliefs of this population as compared to patients with a private dental care plan;

(e) All licensed dental care providers can participate; and

(f) Federal Budget 2023 financial commitments for the CDCP to keep pace with inflation and utilization growth.

Key Stakeholders and Their Leading Priorities

A successful plan must earn broad support from key stakeholders, each with varying priorities and interests. Fortunately, the foundational purpose and goals of this plan are shared: a fiscally prudent plan, subject to sensible management and oversight, that promotes oral healthcare and financial security for eligible Canadian families. We have designed our models within these goalposts and with consideration given to these genuine and good faith concerns, based on rigorous consultation, research and analysis.

The following sets out **our understanding** of the key priorities for selected key stakeholders:

Selected Stakeholder Group	Key Priorties
Eligible participants *Individuals who will be eligible to participate in the CDCP, with special considerations for seniors, persons with disabilities and low-income families*	• Improved oral health • Increased financial security • Choice of oral healthcare provider • Patient-centred care; the primacy of the patient-dentist/provider relationship • Dignified user experience • Appropriate access to care (accessibility, affordability, acceptability, adequate capacity and ease of use for registration, benefits terms and payment processes)
Canadian taxpayers who are not eligible participants	• No increased tax burden • No derogation of their access to dental care services • Improved oral health for all Canadians • Increased financial security for family members who are eligible participants

The Government of Canada *The Government of Canada, including Finance Canada, Health Canada and the Privy Counsel Office.*	• Improved oral health for eligible participants • Increased financial security for eligible participants • Fiscally prudent and sustainable plan • Co-existence with existing dental care benefits regimes (e.g., individual plans, employer sponsored group plans, provincial programs) • Accessible (i.e., good utilization and ease of use) • Delivers the government's promise
Employers *Canadian employers and similar groups, including those who currently provide or contribute to group dental health insurance as an employee benefit and those who do not*	• Ensuring competitive dental care coverage for employees • Potential cost savings (and no increases) on dental care benefits • No increased tax or other financial burden
Dental Health Insurers *Insurance companies that provide financial coverage and/or administer group dental health plans*	• Maintain strong core business • Insight to actuarial data • Support for employers to retain existing dental benefits plans • For some, a potential role in administering the Canadian Dental Care Plan
Dental Care Professionals *The providers of dental care services, including dentists, dental specialists, hygienists, technicians, nurses and laboratories (and including operators of dental care clinics and similar facilities)*	• Optimal oral health and holistic care – priority on prevention • Patient choice of oral healthcare provider • Patient-centered care; the primacy of the patient-provider relationship • Harmonized with existing claims administration processes • Remuneration structure harmonized with recognized provincial and territorial suggested fee guides • Accessible (i.e., capacity; sufficient staffing; ease of use) • Preserves and can co-exist with existing insured/ employer-provided benefits

Our consideration of the key stakeholders has prompted focus on the following **priority themes:**

Improved oral health for eligible participants

Routine diagnostic and preventative care for eligible participants are often less expensive and more beneficial for long-term oral health than treating oral disease once it has arisen. An oral health care system that focuses on improved access to oral health care and preventing disease is more sustainable and will lead to improved oral health outcomes. A report published in 2021 by the Canadian Dental Association found that the lack of dental coverage for many Canadians is a significant barrier to accessing dental care. Providing coverage for currently uninsured Canadians would result in improved oral health outcomes, reduced healthcare costs, and increased economic productivity. There is a need to include special care supplemental access for high-risk patients, and this should be costed into the program.

Increased financial security for eligible participants

The cost of dental care for uninsured Canadians often leads to the difficult decision to forego or delay necessary dental treatments because of financial constraints or competing financial priorities. Surveys and studies report that among the leading financial worries of low-income Canadians is access to affordable health and dental care. Studies show that Canadians who cannot afford dental care are more likely to have worse oral health outcomes, resulting in a greater need for dental treatment.[1]

Compounding the cost of dental care for low-income Canadians is the issue of lost wages: potentially over 40 million hours are lost annually due to dental problems and treatment in Canada, with subsequent potential productivity losses of over $1 billion dollars.[2] However, avoiding preventative dental care often results in more complex problems and more invasive treatments at a later stage, which are often accompanied by higher costs and more time off work.

The Canadian Dental Care Plan (CDCP) will provide meaningful and immediate relief to these issues. Prioritizing diagnostic and preventative dental care as tools to maintain good oral health and prevent small problems from becoming complex, painful and expensive ones, our model assumes:

(1) no co-payments, no deductibles, no co-insurance, no contributions to premiums, and no out-of- pocket payments by eligible participants, in accordance with the Government of Canada's representation; and

(2) alignment with provincial fee guides for dental services on an ongoing basis.

(3) Allow higher risk patients more access to preventive care.

The CDCP will play a role in increasing the financial security of Canadians, improving economic mobility by opening doors to education, employment and other life opportunities, improving personal and community well-being, and helping to mitigate negative social outcomes.

Patient-centered care that is safe, effective and dignified, and permits choice of oral healthcare providers.

When patients are involved in their own health and their preferences and values are respected, they tend to be more engaged and invested in their care, which can lead to better adherence to treatment plans and improved health outcomes.[3] Our framework enables and promotes patient-centred care where citizens are empowered to choose their own dentist/provider. Likewise, our framework values autonomy and agency for patients to make informed oral health care decisions together with their dentist as a part of their primary healthcare team (dental home).

Dignified user experience

Canadians who access the Canadian Dental Care Plan should feel respected and empowered, with an active role in their oral health. For example, a low-income senior or child should be part of the same patient experience as other patients in the dental clinic. Patients should be welcome and encouraged to form a trusted partnership with their dentist of choice and have agency and autonomy over their oral healthcare decisions. All people must receive the same attention and high-quality care that is provided to patients with private insurance and should have ready access to the necessary information and advice to make informed decisions about treatment options, risks and benefits.

Eligible participants should be welcome and encouraged to form a trusted partnership with their dentist of choice and have reasonable control and autonomy over their oral healthcare decisions. There should also be a recognition that, prior to the implementation of the plan, some eligible participants may have been forced to forego or postpone oral healthcare for financial or other reasons, which is likely to create higher demand in the early years of the plan. The intrinsic features of our framework will create a dignified user experience, including built-in incentives to ensure that eligible participants can seamlessly access care the same way as privately insured patients, including timely and fair access to appointments, services, information and follow-up. Our framework also includes flexibility to accommodate higher demand in the early years of the plan so that eligible participants can access treatments that may have been postponed.

Accessibility

To be successful, the Canadian Dental Care Plan must be accessible for eligible participants and dentist providers. Maximizing accessibility will improve oral health outcomes and reduce heath disparities, particularly for vulnerable populations and individuals who may have experienced barriers to accessing healthcare, whether financial, cultural, educational, language, social stigmas, or other barriers.[4] An accessible plan will promote strong uptake and utilization, allow higher risk patients more access to preventative care and achieve the primary goal of improved oral health for eligible participants. The targeted populations in all three plans have elements that do not have access because of where they live or their condition of disability.

This theme permeates our framework, including automatic or frictionless enrollment/ registration for patients, maximum affordability (by properly funding the program on an ongoing basis, the federal government can obviate the need for copayments for Canadians under the $70,000 income threshold, deductibles, coinsurance or contributions to premiums, and no out-of-pocket payments by eligible participants), simplicity of plan terms, adequate staffing and capacity in dental clinics by making the program fair to dentists and other providers, use of the existing practical payment and administration process, and flexibility to accommodate special circumstances.

Fiscally prudent and sustainable program

Canadian studies show that lack of access to regular dental care appointments, either due to an inability to attend or afford care, leave people more likely to visit emergency departments for dental problems not associated with trauma.[5] These visits result in a significant financial burden on the public health system.[6] It has long been the view of policy stakeholders that the use of emergency department visits to address dental problems is both highly inefficient and costly to the healthcare system.[7] Similarly, poor oral health can impact a person's ability to work and earn a living and can have various adverse mental health and social impacts.

Using a proprietary dataset obtained from dental care providers in every province and territory of Canada, and with assistance from a leading economic research firm, we have conducted extensive analyses, modelling, and projections to verify that our framework conforms with the announced budgetary parameters. All stakeholder groups, including eligible participants and dental care providers, want this plan to be successful– there is a shared commitment to designing a plan that is fiscally prudent, sustainable over the long term, manageable, and fair.

Co-existence with employer-provided dental care regimes

An important but challenging priority of stakeholders is to minimally disrupt employer-provided dental care plans. One of the federal government's stated objectives for the Canadian Dental Care Plan (CDCP) is to provide affordable dental care for uninsured Canadians. To support the success of the plan, it is important that most employers are motivated to maintain robust dental care coverage for their employees, including those employees who, but for such private coverage, would be eligible for the CDCP. Most employers should continue to offer competitive dental care and other healthcare and benefits as a tool to recruit and retain employees and distinguish themselves in a competitive marketplace. Our framework includes features and terms designed to promote this outcome. The federal government may have other tools, whether through tax incentives or otherwise, to align stakeholder interests and promote the intended outcome.

Maintain core private insurance business

Insurance companies and other providers of private dental care plans are important stakeholders in the oral healthcare – and broader healthcare and employment benefits – ecosystem. These businesses have designed, offered and administered effective and innovative solutions for decades, which have given millions of Canadians peace of mind and access to affordable health and dental care. Given its purpose of providing affordable dental care for uninsured Canadians, the Canadian Dental Care Plan (CDCP) should avoid disrupting this model. As discussed above, it is important that all or most employers are motivated to maintain robust dental care coverage for their employees, including those who would otherwise be eligible for the CDCP. Achieving this priority will require creative solutions and thoughtful compromises, and collaboration between the government, employers and the insurance industry. Our framework includes potential features and terms designed to promote this outcome.

Harmonized with existing claims administration and remuneration processes

It is important that the Canadian Dental Care Plan (CDCP) is fair, and easy to manage and administer. Most dental clinics in Canada are already integrated with systems and platforms that streamline claims reporting and payments between patients, dentists and insurance companies. In many cases, these systems and the related practices and procedures can be leveraged to manage and administer the CDCP, including reporting and other tools to monitor for errors and outlier claims. Similarly, the dental associations (or similar organizations) in every province and territory in Canada have developed dental fee guides setting out the suggested fee for many dental procedures based on various factors and widely accepted benchmarks, including the time required to complete the procedure, the complexity of the procedures, and the costs of materials, equipment and other overhead. Harmonizing the plan with these fee guides will ensure regionally appropriate pricing, incentivize dental care providers to maximize capacity (including by making investments

in staffing, equipment, technology and other resources) and, importantly, ensure that eligible participants are treated with dignity and not perceived as less important than other patients who have private insurance coverage (including by promoting timely and fair access to appointments, services, information and follow-up).

It is important to remember that the provincial and territorial fee guides are suggested fees only and not binding on dental care providers, some of whom elect to charge more or less for their services. To promote the important plan priorities discussed above, our framework contemplates payment of the full suggested fee in the applicable fee guide. This approach will compensate dental care professionals fairly for their services and encourage maximum capacity in the system.

Eligible Population

The charts below reflect the population eligible for the Canadian Dental Care Plan (CDCP), divided by income and eligibility, based on our data projections.

CDCP – Eligible Population (2023)			
	Children under 18, seniors and individuals with disabilities	Employer sponsored or government dental plan	Individuals meeting all eligibility criteria
Individuals with an annual family income of less than $70,000	5,629,600	2,285,600	3,344,000
Individuals with an annual family income of $70,000 - $90,000	2,192,900	1,311,400	881,500
Totals	**7,822,500**	**3,597,000**	**4,225,500**

The chart below is adjusted to account for wider eligibility under the CDCP in 2025.

CDCP – Eligible Population (2025)			
	All Individuals	Employer sponsored or government dental plan	Individuals meeting all eligibility criteria
Individuals with an annual family income of less than $70,000	11,821,300	4,799,400	7,021,900
Individuals with an annual family income of $70,000 - $90,000	5,044,400	3,016,600	2,027,800
Totals	**16,865,700**	**7,816,000**	**9,049,700**

Canadian Dental Care Plan (CDCP) Menu

Taking into account these key stakeholder priorities, we have run data models on five possible dental care plan design options with relevant outcomes.

Assumptions *(may be adjusted to estimate the outcome)*

The Canadian Dental Care Plan (CDCP) Menu below projects costs that assume the variables listed. Our database has the capability to vary these figures and adjust for any of the listed assumptions to reflect more accurate pricing, with the exception of the ability to adjust to account for no annual limits.

- No de-insurance
- 100% participation by eligible individuals
- No fee guide increases
- 2023 provincial fee guide for applicable province is used for pricing
- Values for Canada are sums of all provinces
- People using CDCP will access services in the same way as people who currently have a dental plan
- No annual limits on services are applied

	2023		2025	
Plan	**Direct Cost**	**Cost Per Eligible Person**	**Direct Cost**	**Cost Per Eligible Person**
1. Emergency Only (No Specialists)	$797,533,000	$188.75	$1,659,617,000	$183.39
2. Selected Diagnostic and Preventative Care (No Specialists)	$775,380,000	$183.50	$1,627,458,000	$179.84
3. Full Care Coverage*	$2,194,502,000	$519.35	$4,570,024,000	$504.99
4. Main Care Coverage**	$2,131,789,000	$504.51	$4,443,694,000	$491.03
5. Specialty Care Coverage***	$227,527,000	$53.85	$472,290,000	$52.19
6. Full Coverage Care with copay for $70,000-$90,000****	$2,102,147,000	$497.49	$4,495,516,000	$496.76
7. Full Coverage Care with copays****	$1,831,327,000	$433.40	$3,815,860,000	$421.66
8. Full Coverage Care with copay for $70,000-$90,000, assuming 30% deinsurance****	$2,633,907,000	$496.53	$5,652,816,000	$496.10

Refer to Annex A for further analysis on care coverage with further co-pays

* based on Non-insured health benefits (NIHB) services package
** based on NIHB services package that does not require pre-authorization
*** based on NIHB services package of all services that require pre-authorization
**** based on federal employee plan and copay structure

An Oral Health Spending Account as an Effective Program Solution

As we work towards a Canadian Dental Care Plan that respects patients, providers and taxpayers, the federal government could consider a temporary expansion of the interim measure that is already in place – the Canada Dental Benefit. This is a fixed dollar amount that a patient can use to be reimbursed for dental-related expenses. Nearly nine out 10 Canadians support the Canada Dental Benefit, and our survey work suggests that the majority of Canadians would support an oral health spending account as a permanent solution. An oral health spending account could empower patients, mitigate the de-insurance risk, and increase access to dental care now. See Annex B for more details.

- In Canada, most private employer-based dental plans provide users with their essential dental needs and offer flexibility in provider choice and what services are most pertinent.
- With an Oral Health Spending Account (OHSA), administrative hurdles are kept at a minimum, resulting in the provision of quick and seamless dental care, along with there being theoretically no barriers to dentist participation, unlike what will be expected for an NIHB-type plan.
- The current Canada Dental Benefit for children has been operating as a de-facto open-ended OHSA, with a hard cap, using the current claims infrastructure in place, resulting in high satisfaction levels for the participating children and their parents. This has resulted in appropriate and efficient dental care delivery for this limited group.
- If the Canadian Dental Care Plan (CDCP) is administered as an OHSA, and there is no hard cap, then accountability and spending controls could be introduced, such as frequency and/or coverage limitations found in private dental insurance plans, as well as federal public plans like the NIHB.
- Spending accounts provide an incentive to use the available funds, thus empowering patients to be aware of their health, seek care and collaborate with their providers to obtain those services that are deemed most important by the patient-provider.
- An OHSA would most likely prevent employers dropping private health insurance plans for employees, over an NIHB styled or another service-specified plan.

De-Insurance Risk and Budgetary Impact

Executive Summary

1. Employer-sponsored dental care benefits are a real and direct cost to employers and employees.

2. Many employers and employees will wish to end their provision of/participation in employer-sponsored dental care coverage for employees who otherwise would be eligible for the Canadian Dental Care Plan (CDCP).

3. If this risk materialized, the pool of eligible participants for the CDCP, and its cost, could expand *significantly*.

4. Without any mitigation strategies, the potential pool of eligible persons could grow from the estimated 9 million to approximately 17 million.

5. A wait-and-see approach may open the CDCP to criticism of creating unintentional "corporate subsidies" and incentivizing employers to drop private dental coverage for lower-income employees.

6. A set of moderate mitigation steps may reduce the potential pool expansion.

The De-Insurance Risk

Many employers and employees will wish to end their provision of or participation in employer-sponsored dental care coverage for employees who would be otherwise eligible for the Canadian Dental Care Plan (the CDCP). If this risk materialized, the pool of eligible participants for the CDCP, and its cost, could expand *significantly*.

Overview

As currently proposed, the Canadian Dental Care Plan (CDCP) would define eligible participants, in part, as those persons (i) with a family income below a specified dollar amount and (ii) who are not eligible for dental care coverage through their own employment or as a dependant. Many persons who would meet this family income test would be ineligible for the CDCP by virtue of having access to employer-sponsored dental care coverage. Many employers in Canada offer some form of dental care benefits as a tool to recruit and retain workers and to promote a healthy and productive workforce. In many cases, employees pay a portion of the costs of the insurance premium, often as a direct deduction from their paycheques, and services are subject to a copayment and/or deductible amount. In Québec, dental care benefit provided by an employer are deemed a taxable provincial benefit to the employee, such that value of the benefit is added to the employee's income and is subject to income tax. In other words, providing and participating in employer-sponsored dental care benefits is a real and direct cost to the employer and employee.

In the circumstances described above, a rational business can be expected to consider reformulation of employee benefits packages to exclude dental care coverage for those employees (and their dependants) who would otherwise be eligible for the CDCP. Similarly, it would be rational and expected for employees to encourage their employers to terminate or curtail any dental care coverage under employee benefits packages that would overlap with the CDCP coverage in order to avoid or reduce the associated costs to the employee (i.e., in many cases, direct contributions to premiums and copayments or deductibles). Similarly, care will be required in defining "eligible persons" under the CDCP so that the program is not misaligned with eligibility under other public programs. A report published in 2004 by The Robert Wood Johnson Foundation concluded that "[t]o achieve meaningful reductions in the number of uninsured, some amount of crowd- out seems inevitable. This dilemma arises in all initiatives to expand coverage, and becomes more prominent as policy-makers seek ways to assist moderate-income uninsured families."[8] In sum, the risk is that relevant employers and employees may conclude that it is not prudent or rational to offer to participate in employer-sponsored dental care coverage that overlaps with the benefits otherwise available under the CDCP. Going forward, it is unlikely that any employer will offer overlapping dental care coverage to new employees who would otherwise qualify for the CDCP.

Scope of Risk

Health Canada has estimated that approximately 9 million Canadians would qualify for the Canadian Dental Care Plan (CDCP) if there was no change to the number of persons who are ineligible for the CDCP by virtue of having access to employer-sponsored dental care coverage. However, academics have cautioned that "crowd-out" (referred to here as the "de-insurance risk") is difficult to measure and is highly sensitive to the underlying assumptions and data. Based on a survey conducted by Abacus Data, as of March 2023, approximately 7% (+/- 1.6%) of employed Canadians reported receiving some indication from their employer towards a decrease (or elimination) in dental benefits as a result of the interim federal dental plan.

The Definitional Challenge:

Parliament is set to pass the omnibus 2023 Budget approval bill, including Division 29, the Dental Care Measures Act, which legislates the necessary apparatus for the Canada Revenue Agency to compel dental care coverage information from persons who file tax information with respect to payees, and to use that information in administration of the Canadian Dental Care Plan (CDCP). For our purposes, the operative clause of the Dental Care Measures Act is section 4.1, which effectively says that every person who files tax information in respect of "payees" must indicate if the payee or family members were, in that tax year, "eligible in respect of the payee's [or spouse's] employment […] to access any dental care insurance, or coverage of dental services of any kind, offered by the person." Taken in totality, along with other public statements promoting the plan, there are public policy markers that any person in Canada will be eligible for the CDCP if the person: (a) has an annual family income under $90,000; and (b) is not eligible for private dental coverage provided by an employer. Care will be required in defining "eligible persons" under the CDCP so that the program is not misaligned with eligibility under other public programs.

Projected Impact

The following table shows estimates of the impact on Canadian Dental Care Plan (CDCP) eligibility and CDCP cost resulting from various potential outcomes of the de-insurance risk.

	2024		2025	
	Increase in Eligible Persons	Increase in Cost	Increase in Eligible Persons	Increase in Cost
10% De-Insurance	359,700	$175,605,000	781,600	$384,769,000
20% De-Insurance	719,400	$351,210,000	1,563,200	$769,537,000
50% De-Insurance	1,798,500	$878,026,000	3,908,000	$1,923,842,000
90% De-Insurance	3,237,300	$1,580,447,000	7,034,400	$3,462,915,000
Largest 10 private sector companies de-insure employees earning <$90,000/year (estimate)	503,800	$245,955,200	503,800	$248,010,700

Potential Mitigation Strategies

The information below serves as a summary of potential mitigation strategies attempted in other jurisdictions or discussed by health policy academics or other researchers. The following is intended only for discussion. This Briefing Note does not provide analysis on the policy desirability or impact of mitigation options.

1. Relationship Leverage

Overview:

The Government of Canada could deploy its significant relationship capital to make clear to the private sector (including insurance companies and major employers) that the Canadian Dental Care Plan (CDCP) is intended to fill an existing need/gap in the market and to articulate the clear expectation that the government expects most businesses to continue to offer dental care coverage as part of most employee benefit packages. This strategy could be deployed alone or in conjunction with any other mitigation strategies. This expectation-setting could be softer or harder as necessary, perhaps including a possibility of a future legislative solution.

Benefits:

- Emphasizes policy intent, requires no significant re-design.
- Allows an opportunity to "chill" de-insurance risk by calling attention to it; sets up possible revisions to CDCP if needed in response to risk materialization.

Drawbacks:

- Relies on private sector relationship-based cooperation.
- This is effectively an exhortation, not a policy, regulation or official interpretation.
- Draws attention to the opportunity of de-insurance risk.

2. Enterprise-Wide Benefits Test

Overview:

Design the CDCP such that persons are ineligible for the CDCP if their employer provides access to any dental care coverage for any of its employees (including those earning more than the specified CDCP threshold). For example, even if a person had a family income below the CDCP threshold, that person would be ineligible for the CDCP if their employer provided access to dental care coverage for senior executives. For many employers, this approach would likely create a strong moral obligation to not eliminate (and perhaps to introduce) employer-sponsored dental care coverage for lower-income employees, while maintaining such coverage for higher-paid employees.

Benefits:

- Reduces ability for employers to re-formulate private dental coverage plans to "shift" low-income employees to CDCP.
- Introduces a new moral dynamic that may encourage employers to maintain (and possibly introduce) employer-sponsored dental care coverage for their lower-income employees.
- Motivates desired behaviour in private market to support the policy objective behind tax-free health and dental benefits.

Drawbacks:

- Potential perception as a policy over-reach, with lower-income employees bearing the burden of negotiating with their employer to achieve the desired outcome.
- Potential "over-exclusion" of a sub-set of low-income workers who currently do not have private dental coverage, even though higher paid employees do, as a consequence of a private employer's pre-CDCP business decisions.
- Risk that employers will adopt creative structures to "work-around" the policy intent.
- May create a "race to the bottom", where businesses offer only the minimum standard of dental care coverage, or pass-on a disproportionate cost to the employee.

3. Tax or Legislative Inducements

Overview:

Design and implement ancillary tax or other legislative inducements designed to motivate certain businesses to maintain dental care coverage for employees that could otherwise migrate to the CDCP, or to help off-set the cost of such migration. Several types of legislation or policies could be introduced to motivate businesses to provide dental care benefits to their lower-income employees. *For example:*

- **Tax incentives:** Governments could offer additional tax incentives to businesses that provide dental care benefits to their employees who would otherwise be eligible for the CDCP. These incentives could be in the form of tax credits or other inducements.
- **"Pay or provide":** Consider new tax policies that require large employers to either provide private dental coverage to low-income employees or contribute to the cost of the CDCP (e.g., through a new tax levy). The policy could specify a minimum standard for "reasonable" coverage. A regime of this nature could be applied, for example, to businesses that have over 100 employees or more than $5 million in revenue (the measure used by the Treasury Board of Canada Secretariat for a variety of categorization purposes).

Benefits:

- Measured financial incentives or disincentives are likely to have the most impact to drive the desired outcome/behaviours, namely maintenance of existing dental plans.
- Measures of this nature directly underscore the policy intent to provide oral health care and financial relief to families without access to insurance.
- Measures of this nature can be targeted to specific market actors (e.g., insurance companies, business above a specific scale, etc.) and can be adjusted over time as their impact is measured.

Drawbacks:

- May be considered a policy over-reach.
- Measures of this nature have not been part of the government of Canada's public statements or commentary to date – may be perceived as a late and substantial shift in policy.

4. Supplementation of Benefits

Overview:

Design the CDCP such that persons with access to employer-sponsored dental care coverage are not disqualified from the CDCP – but, instead, such persons could retain both coverages, subject to the CDCP being available only for supplemental dental care that is not otherwise included under or covered by the employer-sponsored coverage.

Benefits:

- Creates a consistent baseline of dental care coverage for all persons who are eligible for the CDCP.
- Recognizes the wide variation in the nature of dental care coverage that employers are able or willing to provide, without jeopardizing the needs of lower-income Canadians.
- Consistent with standard industry practices related to the coordination of benefits.

Drawbacks:

- Likely incentivizes employers to minimize dental care coverage for employees who would be eligible for the supplemental coverage under the CDCP.
- May create a problematic expansion of the pool of eligible participants under the CDCP, even if the financial exposure for some of those participants would be lessened by treating the CDCP as supplemental coverage.

Dental Services Fee Guides

Executive Summary

1. In Canada, a suggested dental services fee guide is established by the dental association in most provinces and territories and reviewed and analyzed by practicing dentists and independent economists.

2. Fee guides are designed to promote fairness, transparency, confidence and predictability for patients and dentists, while also promoting regionally appropriate pricing, but are not binding on dentists.

3. Fee guides have been shown to promote affordability and accessibility in dental care.

4. Dental care programs that minimize administrative burden and fairly compensate dentists result in improved patient access, higher rates of utilization and an increase in the delivery of preventive care.

5. Many dentists in Canada have busy practices. The Dental Care Plan (CDCP) should encourage dentists to participate in the program, make investments in their practices and accept new patients.

6. Various studies suggest that paying for services in-line with suggested fee guides will encourage dentists to accept new patients, reduce wait-times, increase capacity, and create fairness between public and private patients.

7. It is difficult to draw meaningful comparisons between the Non-Insured Health Benefits (NIHB) Program and the CDCP. The NIHB is highly tailored to the unique needs and circumstances of First Nations peoples, covers a broad set of healthcare services beyond dental services (including pharmacy and transportation), is expensive to deliver and has relatively low utilization.

Understanding Dental Services Fee Guides

Purpose

In Canada, a suggested dental services fee guide is established by the dental association in most provinces and territories. The fee guides are established at least annually and provide a suggested fee or range of fees for dental services that dentists may use as a reference point when setting their own fees. However, the fee guides are not binding on dentists, who are free to charge higher or lower fees. A dentist's decision to charge different fees is normally based on their own expenses and the supply and demand context of their practice. Fee guides are designed to promote fairness, transparency, confidence and predictability for patients and dentists, while also promoting regionally appropriate pricing. Fee guides also utilize a uniform and widely recognized set of procedure codes that allow for the efficient processing, administration and monitoring of claims and program usage across the country.

Methodology

Suggested fee guides are intended to reflect fees that are based on reasonable and prudent requirements of scientific knowledge, professional judgement and technical skill under normal operating conditions.

Each suggested fee is based on a complex formula that seeks to weigh numerous factors and considerations, with specific methodologies that vary between jurisdictions. Some common factors and considerations include the time required to complete the procedure, the complexity of the procedure, the degree of responsibility being undertaken by the dentist (related to scientific knowledge, professional judgement, technical skill and risk to perform the procedure), the cost of materials, equipment and other overhead, available supply and demand data, and the current and projected state of the economy in the applicable jurisdiction.

Fee guides are developed using a comprehensive methodology and significant rigour, which commonly include the following:

Data collection: The data collection process for dental fee guides involves gathering detailed information on the costs of running a dental practice and the time and resources required to perform various procedures. Dentists are typically asked to provide data on their practice expenses, including rent, equipment, supplies and staff salaries.

Peer review: The data collected for the fee guide is typically synthesized by independent economists for review by the economics committee of the applicable provincial or territorial dental association. This peer review process helps ensure that the suggested fees fairly represent the costs of providing dental services in the applicable province or territory.

Transparency: To ensure transparency and accountability, the suggested fee guides are published and available to patients and the broader public through public libraries, to the extent a copy has been requested.

Impact on affordability

Dental services fee guides have long been a tool to promote transparency, affordability, and accessibility in dental care. They are an important tool enabling patients to compare the fees a dentist is proposing for a treatment plan to the fees suggested by the applicable dental association. This information can help patients make informed decisions and thereby reduce financial barriers to accessing dental care. The use of fee guides has been shown to contain the cost of dental services. Predictability of dental care costs can alleviate anxiety for individuals who are worried about otherwise overstretched budgets.[9]

Impact on dentist participation and patient utilization

Dentists in Canada are busy. Many dental clinics have limited ability to accept new patients, often due to shortages of dental assistants or dental hygienists. A 2019 survey of the Canadian Dental Association (CDA) found that 36% of dental practices were seeking to fill a dental assisting position. Based on a recent survey commissioned by the CDA,[10] approximately 25% of patients who sought a dental appointment were unable to book one within a "reasonable near-term" and, among those who were unable to book such an appointment, almost 60% gave up and postponed dental care. Further, approximately 10% of patients have had a dental appointment cancelled in the past two months, typically because the dentist or dental hygienist was unavailable. Perhaps more problematically, based on a recent survey by the CDA, only 61% of Canadians report having a dentist that they see regularly,[11] which is likely to be worse following the challenges of the pandemic.

The Canadian Dental Care Plan (CDCP) will create a need to accommodate a large influx of new patients and provide a dignified experience for eligible participants. As discussed above, eligible participants should not be last in the appointment queue, hurried through dental appointments, or be seen as a less important patient in a dental clinic. Success will require program design features that encourage dentists to participate in the CDCP, accept new patients, reduce wait-times, and make investments in their practices.

Various studies suggest that some health care providers will avoid or minimize participation in public programs that are perceived to under-compensate for services or present administrative barriers.[12] For example, a 2010 Canadian study published in the Journal of Public Health Dentistry concluded that dentists in general are not satisfied with the fees paid to them by public programs, and sometimes are not willing to see publicly insured patients (both because of the low fees and the associated administration).[13] That study found that, as a result, over 30% of dentists had reduced the number of publicly insured patients in their practice. When asked what specifically bothers them about publicly financed care, on average, dentists noted five things, indicating most frequently the limited services covered, low fees, broken appointments, slow payment, and denial of payment.[14] Similarly, a number of U.S. studies have found that in states with higher Medicaid payment rates, provider participation levels are higher (for example, as measured by their willingness to accept new Medicaid patients in their practice).[15,16] These studies also suggest that access to care could be greater for patients living in higher-fee states, such as patients being more likely to report having a usual source of care,[17] having higher rates of outpatient visits and greater delivery of certain preventive treatments.[18,19,20] To the extent that higher fees increase the likelihood that patients receive the necessary care, raising fees could also improve health outcomes and reduce healthcare costs by decreasing inappropriate use of the emergency department and/or hospitalizations, especially for preventable oral health diseases.

Healthy Smiles Ontario: *A Case Study from Ontario:*

The Healthy Smiles Ontario program (HSO) is a public dental care program in Ontario for paediatric patients. Launched in 2016, HSO replaced several previous paediatric programs, with an aim to ensure greater access to dental care for children in need. In 2017, the Ontario Dental Association commissioned and published a study to understand Ontario dentists' experience with and attitudes regarding the HSO program.[21] The key findings included the following:

- The study concluded that dentists were very dissatisfied with their HSO experience, particularly with the low fees they received, which were below the costs of delivery care, and anticipated limiting their participation in the program.
- Dentists further reported that the reimbursement fees under the HSO did not even cover their overhead costs, requiring dentists to incur a loss on each HSO patient they treated. Only 5% of participants indicated that their overhead costs were covered by the HSO fees.
- Most dentists who participated in the HSO program reported doing so for altruistic reasons, personal satisfaction and out of a sense of professional duty, with many participating out of a concern that patients would be left untreated.
- Dentists also reported various administrative burdens with the program, such as difficulty receiving reimbursement and compliance challenges with patients.
- Many dentists felt frustrated for essentially funding the program.
- Specifically citing the low fee reimbursement rates, almost half of surveyed dentists expected to reduce or limit the number of new HSO patients that they took on during the following 12 months.
- However, dentists reported that if the HSO fees were raised to customary levels, 75% of them would increase the number of HSO patients that they accept.

Dental care programs that minimize administrative burden and fairly compensate dentists result in improved patient access, higher rates of utilization and an increase in the delivery of preventive care. For example, a 2022 briefing[22] prepared by the First Nations Health Authority of British Columbia reviewed the impact of easing certain administrative burdens and increasing fee reimbursement rates following the transfer of the administration of the Non-Insured Health Benefits (NIHB) program from Health Canada to the First Nations Health Authority in British Columbia. These changes, among others, led to a steady increase in utilization of dental care coverage, with a 10% increase in claimants, and a 14% increase in claimants undertaking preventative services. (Please see the case study below entitled, *Reforming the NIHB: A Case Study from British Columbia.*)

The treatment experience of patients in public dental programs often falls short in comparison to patients with private insurance. A primary reason for this is the lack of active participation by dentists in these programs. To be successful, the Canadian Dental Care Plan (CDCP) must be designed so that dentists are motivated to participate and are supported when they deliver quality dental care.

A CDCP framework could maximize both dentist participation and the patient experience by reimbursing dentists at the full amount suggested in the applicable fee guide. This approach will compensate dental care professionals fairly for their services, encourage maximum participation in the program and put public and private patients on an equal footing.

Apples to Oranges: Comparing the Non-Insured Health Benefits Program & Canadian Dental Care Program

Overview

The Non-Insured Health Benefits (NIHB) Program provides registered First Nations and recognized Inuit peoples with coverage for a broad range of medically necessary health benefits and ancillary services. Unlike the Canadian Dental Care Plan (CDCP), in addition to dental care, the NIHB also covers prescription pharmaceuticals and over-the-counter medication, vision care, mental heath counselling, medical supplies and equipment, and medical transportation to access required health services not available on reserve or in the community of residence.

It is difficult to draw meaningful comparisons between the NIHB and the CDCP. The NIHB is highly tailored to the unique needs and circumstances of First Nations and recognized Inuit peoples. In addition to providinghealth care, various features of the NIHB are designed to respect important cultural sensitivities and overcome enormous barriers to access, exacerbated by generational failures such as historical trauma and institutional racism. In short, the NIHB is specifically designed to address specific needs and challenges in a specific population.

To be successful, the CDCP must also understand and accommodate the business costs relating to the operation of a dental office (which can be considered along the lines of a small hospital).

Eligibility and program expenditures

During its 2020/21 program year, approximately 900,000 persons were eligible to participate in the NIHB and aggregate program benefit expenditures were almost $1.5 billion, or approximately $1,700 per eligible person (which per capita amount would be higher if calculated based on persons who accessed care under the NIHB; but such data does not appear to be published). By contrast, the CDCP is intended to cover approximately 10 to 13 times more people. Health Canada has estimated that a minimum of approximately 9 million persons will be eligible for the CDCP (which number could increase to approximately 12 million with a 50% realization of the de-insurance risk). Further, the NIHB program has entirely unique budgetary considerations when compared to the CDCP. For example, during the 2020/21 program year, almost 73% of all program benefit expenditures under the NIHB were attributable to pharmacy and medical transportation. During that period, dental care services accounted for only about 16% of program benefit expenditures.[23]

NIHB dental services and utilization

The NIHB covers a wide range of dental care services (plus required transportation services to access such care, as well as medications and medical supplies and equipment). Dental care services include:[24]

(a) diagnostic services (such as examinations and radiographs);

(b) preventive services (such as scaling, polishing, fluorides and sealants);

(c) restorative services (such as fillings and crowns);

(d) endodontic services (such as root canal treatments);

(e) periodontal services (such as deep scaling);

(f) removable prosthodontic services (such as dentures);

(g) oral surgery services (such as extractions);

(h) orthodontic services (such as braces); and

(i) adjunctive services (such as general anaesthesia and sedation).

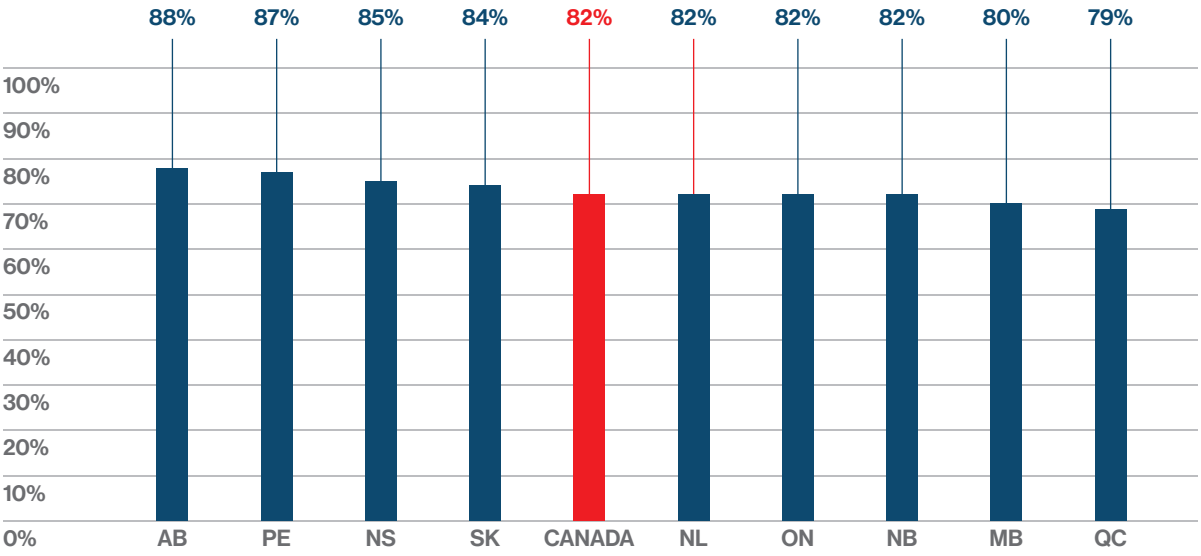
Utilization of dental care services under the NIHB is low, with approximately 36% of eligible persons accessing dental care services during a typical program year. During the 2020/21 program year, a total of 267,032 eligible persons (being approximately 29% of all eligible persons) accessed dental benefits though the NIHB program, likely driven lower by the pandemic. During that period, dental claims represented $236,300,000 (or approximately 16%) of total program benefit expenditures.[25] By contrast, a typical employer-sponsored dental care plan will have almost 60% utilization.[26]

These comparisons only underscore the unique nature of the NIHB and the population it is designed to serve, which is different from individuals on employer-sponsored dental insurance whose social determinants more often correspond to a generally healthy, educated individual with a moderate or high income and living or working in reasonable proximity of a dental practice. Just like the NIHB, the CDCP is also being designed to serve specific disadvantaged populations. The participation in Canadian Dental Care Plan (CDCP) will vary depending on the services provided and, apart from reimbursement rates and administrative barriers, there will undoubtedly be numerous social, logistical and health equity factors that could affect participation, including remoteness/proximity to dental clinics or specialists, language or education barriers, pre-existing health conditions that make travel difficult, differing values/beliefs, and various social and socio-economic determinants.

Reimbursement of dental care providers

Under the Non-Insured Health Benefits (NIHB), dental care providers are reimbursed pursuant to a dental benefit pricing "grid" that sets out procedure codes and reimbursable amounts for covered procedures, with a specific fee grid for each province and territory. The reimbursable fees in the NIHB fee grids are significantly lower than the fees set out in the suggested fee guides established by the provincial and territorial dental associations. The chart below provides a snapshot of these variations based on an analysis conducted by the Canadian Dental Association of the top 100 most frequently used procedure codes. Based on this analysis, if the Canadian Dental Care Plan (CDCP) reimbursed dentists based on the NIHB fee grid, dentists in Canada (and/or people who have private dental insurance or are otherwise not eligible for the CDCP would be essentially subsidizing the cost of the CDCP.

Provincial Suggested Fee Guides vs NIHB Schedule Fees:
Top 100 Most Common Procedures 2022 *Weighted Average, Excluding B.C. Data*



* Procedure codes in Québec do not always match with NIHB procedure codes.

* Data from British Columbia has been excluded because the NIHB has been largely replaced in that province.

Although the NIHB program encourages dental care providers to bill the NIHB program directly and to not "balance-bill" patients, that practice is not mandatory. As a result, in order to realize more customary fees, some dental care providers charge fees to NIHB patients that are above the applicable NIHB fee grid, thereby creating an out-of-pocket copayment obligation on the patient. In addition to low reimbursement rates, the NIHB has other program features that add administrative complexity. For example, eligible persons must specifically register under the NIHB in order to receive dental care (and other) services. In addition, various dental care services require a preliminary consultation with a dental care provider and pre-approval from an adjudication branch of the NIHB (also known as "predetermination") before the services can be performed and the fees submitted for payment. Although some features of this nature are understandable given the unique context of the NIHB, many point to low reimbursement rates and administrative friction (and the resulting delays, wait-times and other constraints), as leading factors that drive low participation by dental care providers and low utilization by eligible persons.[27]

Reforming the Non-Insured Health Benefits: *A Case Study from British Columbia*

As part of a broader transformation project, in 2013 the delivery of most Non-Insured Health Benefits (NIHB) benefits in British Columbia, including dental care, was transferred from Health Canada to the First Nations Health Authority (FNHA). In 2019, the FNHA engaged Pacific Blue Cross to administer the dental care (and certain other) benefits and launched a substantially redesigned program (the FNHA program). Today, all B.C. First Nations persons are covered by this new FNHA program, not the NIHB. The only NIHB patients in B.C. are those First Nations and Inuit persons who are not a member of a First Nation in British Columbia.

The FNHA program was designed to reduce administrative barriers, simplify program navigation and improve the overall patient experience. Prior to these changes, some dental care providers in B.C. were reluctant to accept NIHB patients because of well-known challenges related to NIHB billing and predetermination processes.[28] In addition to removing certain administrative barriers to care, the FNHA program introduced a new fee grid that reimbursed dental care providers at essentially 100% of the suggested fee guides established by the provincial dental association and significantly reduced the number of procedures that required predetermination (from over 200 to approximately 50). The FNHA program also added coverage for certain dental procedures that were of particular need for First Nations elders and placed greater focus on wellness and preventative care.

The FNHA program had a meaningful impact on dentist participation and program utilization. There has been a steady increase in utilization of dental care coverage, with a 10% increase in claimants, and a 14% increase in claimants undertaking preventative services.[29] The FNHA also reports having created a broad network of dental care providers, with almost all dental care providers participating in the program.[30]

Summarizing the impact of the FNHA program before the federal Standing Committee on Indigenous and Northern Affairs in May 2023, Mr. Richard Jock, the CEO of First Nations Health Authority commented that:

"One of the things we've been able to do is get the almost universal buy-in of the providers for this. We have also moved from a very slow and cumbersome paper process to electronic processing. We follow 100% of the fee guide, and […] is done in partnership with and fully endorsed by the dental association of B.C." [31]

The FNHA's initiative involved various changes to a complex program. However, reimbursing dentists in-line with the suggested provincial fee guide and reducing administrative burdens seem to have driven much higher dentist participation and patient utilization.

Annex A — Co-Pay Costing Scenarios

A co-pay is an amount that a person who sees a dentist pays for the services they receive. This is their out-of-pocket expense.

Under the Canada Dental Benefit, participants with an annual family income under $70,000 have no co-pay.

It was announced that in 2023, the Canadian Dental Care Plan will become available to uninsured Canadians under 18, persons with disabilities, and seniors who have an annual family income of less than $90,000. There will be no co-pays for those with an annual family income under $70,000. By 2025, the Canadian Dental Care Plan will be fully implemented to cover all uninsured Canadians with an annual family income under $90,000.

Per Budget 2023, the CDCP will be available to uninsured Canadians with an annual family income of less than $90,000. For those eligible for CDCP who have a family income under $70,000, co-pays will not apply. There will be co-pays for those eligible for CDCP who have a family income between $70,000 to $90,000.

For the purposes of this co-pay costing scenario simulation, we have set an arbitrary amount for a co-pay:

Participants with an annual family income of between $70,000 and $80,000 pay 40% of the fees for services they receive and the CDCP pays the balance.

Participants with an annual family income of between $80,000 and $90,000 pay 60% of the fees for services they receive and the CDCP pays the balance.

We calculate the out-of-pocket expenses using the current fee guides for each province. While all the details will be available specific examples will be presented, e.g., a typical recall appointment, an extraction appointment, a denture appointment. These scenarios will be presented for each of the groups that will have co-pays. The amounts payable will ultimately be determined by the fee schedule that is established.

Scenario 1

Roger (age 69) and Amy (age 65) are both receiving CPP benefits and, along with their work pensions, they have an annual household income of $72,547.

While they were working they had a dental plan that provided benefits of 80% of the provincial fee guide for basic services and 50% for major services. They regularly saw their dentist for preventive care and some restorative work. Since retiring they have only been seeing a dentist when problems arise.

Roger has a partial denture that is 8 years old. It's not fitting as well as it used to and is causing discomfort on his gum.

Amy notices that she has some discomfort on a rear molar. After a week she finds a small lump in her gum beside her tooth. She would like to have a dentist look at it.

They both go back to the dentist they had seen for years. The dentist recommends that Roger replace his partial denture, but more concerning is Amy's lump beside her tooth. She needs antibiotics to control the infection and then a root canal procedure to save the tooth. The alternative is to extract the tooth and replace it with a bridge or a denture.

Roger	
Recall Exam	01202
4 Bitewing	02144
2 Units Scaling	11112
Fluoride	12113
Partial Denture	53201
Lab	$400

Amy	
Emergency Exam	01205
PA	02111
3 Canal Endo	33131
Crown	27201
Lab	$425
Extraction	71201
Bridge	67211
Pontic	62501
Lab	$1,300
Partial Denture	52101
Lab	$400

Scenario 2

Jayden and Ella have two children, Anita and Kim. Together they run a popular restaurant, but neither they nor their employees have a dental plan. Together, they earned $85,975 last year. While Jayden and Ella don't see the dentist regularly they want to ensure their children will have good oral health now and in the future.

The children have been seeing a dentist once a year, but only for regular checkups. Their dentist has recommended sealants for the youngest of them but Jayden and Ella can't fit that into their budget so they have not had them placed.

Kim is at an age where they are starting to build up a small amount of plaque which requires scaling. As well, because sealants were not placed and they were only seeing the dentist once a year, the dentist has identified a small cavity on a molar that requires a filling to avoid future more serious problems.

Anita is young enough that scaling is not required, but without sealants they will be at risk of decay, like Kim has experienced.

Anita	
Recall Exam	01202
Fluoride	12113
2 Bitewing	02142
Polishing	11101
4 Sealants	13401
	13409

Kim	
Recall Exam	01202
2 Bitewing	02142
Fluoride	12113
1 Unit Scaling	11111
1 Unit Polishing	11101
1 Surface Composite	23321

Jayden & Ella	
Comprehensive Exam (Each)	01103
4 Bitewings (Each)	02144
Fluoride (Each)	12113
6 Units Scaling (Each)	11116
1 Unit Polishing (Each)	11101

Scenario 3

Riley is 35 years old and has severe mobility limitations. They meet the criteria for being considered disabled. They are able to do freelance website development which provides them with an annual income of $82,362.

It is difficult for people with mobility limitations to see a dentist. Transportation is an issue, accessing the office is an issue, even being able to sit in a dental chair is an issue, so Riley has not seen a dentist in many years.

Riley is able to find a dentist with an office that is physically accessible and arranges for the local van for people with disabilities to take her to see the dentist.

She has not seen this dentist before so requires a complete examination and x-rays. The diagnostic procedures clearly show that plaque has built up over the years and they are at risk of serious periodontal disease. As well there is substantial decay in two of the molars and a small amount of decay in one of the front teeth.

Root planing is required to deal with the plaque and a four surface restoration is required on one of the back teeth while a five surface restoration is required on the other. The front tooth can be repaired with a one surface filling. The dentist recommends composite fillings for all teeth. An alternative for the severely decayed back tooth would be a crown.

Riley	
Complete Exam	**01103**
4 Bitewings	**02144**
8 Units Root Planing	**43424**
1 Unit Polishing	**11101**
Panorex	**02601**
Fluoride	**12113**
5 Surface Molar	**23325**
4 Surface Molar	**23324**
1 Surface Anterior	**23311**
Crown	**27201**
Lab	**$425**

Scenario 3

Assuming that families with an annual household income of $70,000 to $80,000 have a co-pay of 40% of the 2023 provincial Suggested Fee Guides and those with an annual household income of $80,000 to $90,000 have a co-pay of 60% of the provincial Suggested Fee Guides, this will be the approximate out-of-pocket expense for each of the scenarios. These are likely the minimum amounts as individual cases may require additional services.

Co-Pay									
	BC	AB	SK	MB	ON	NB	NS	PE	NL
Scenario 1									
Roger	$658.38	$745.82	$704.00	$669.84	$768.40	$724.40	$688.00	$639.60	$723.81
Amy	$1,035.36	$1,111.34	$1,016.00	$989.44	$1,084.00	$1,034.64	$973.20	$936.00	$1,149.32
	$1693.72	$1,857.16	$1,720.00	$1,852.40	$1,852.40	$1,759.04	$1,661.20	$1,575.60	$1,873.13
Bridge Alternative	$2,219.96	$2,438.57	$2,230.40	$2,540.40	$2,540.40	$2,311.12	$2,242.00	$2,112.80	$2,549.19
Denture Alternative	$1,109.16	$1,153.98	$1,130.40	$1,261.60	$1,261.60	$1,187.52	$1,253.60	$1,085.60	$1,235.89
Scenario 2									
Anita	$138.60	$205.87	$157.80	$187.80	$162.00	$161.82	$138.60	$139.80	$205.68
Kim	$233.76	$287.86	$237.00	$243.06	$271.80	$236.52	$216.60	$218.70	$262.70
	$372.36	$493.72	$394.80	$430.86	$433.80	$398.34	$355.50	$358.50	$468.38
Jayden & Ella	$672.24	$938.88	$655.20	$759.36	$806.40	$794.28	$628.80	$655.20	$667.39
Family of 4	$1,044.60	$1,432.60	$1,050.00	$1,190.22	$1,240.20	$1,192.62	$984.00	$1,013.70	$1,135.77
Scenario 3									
Riley	$1,169.52	$1,207.85	$1,051.80	$1,109.46	$1,164.90	$1,150.14	$982.20	$985.20	$1,270.95
Crown Alternative	$1,689.12	$1,787.74	$1,601.40	$1,660.38	$1,751.70	$1,709.04	$1,516.20	$1,500.00	$1,930.52

Annex B

The Canadian Dental Care Plan

Oral Health Spending Account as an Effective Program Solution

Executive Summary

1. In Canada, most private employer-based dental plans provide users with their essential dental needs and offer flexibility in provider choice and what services are most pertinent.

2. With an Oral Health Spending Account (OHSA), administrative hurdles are kept at a minimum, resulting in the provision of quick and seamless dental care, along with there being theoretically no barriers to dentist participation, unlike what will be expected for an NIHB-type plan.

3. The current Canada Dental Benefit for children has been operating as a de-facto open-ended OHSA, with a hard cap, using the current claims infrastructure in place, resulting in high satisfaction levels for the participating children and their parents. This has resulted in appropriate and efficient dental care delivery for this limited group.

4. If the Canadian Dental Care Plan (CDCP) is administered as an OHSA, and there is no hard cap, then accountability and spending controls could be introduced, such as frequency and/or coverage limitations found in private dental insurance plans, as well as federal public plans like the NIHB.

5. Spending accounts provide an incentive to use the available funds, thus empowering patients to be aware of their health, seek care and collaborate with their providers to obtain those services that are deemed most important by the patient-provider.

6. An OHSA would most likely prevent employers dropping private health insurance plans for employees, over an NIHB styled or another service-specified plan.

What is a Health Spending Account?

A Health Spending Account (HSA), (also known as a Health Care Spending Account or Health Reimbursement Account), is an individual account with a fixed dollar amount used for reimbursement of a wide range of health-related expenses. Within the insurance sector, an HSA often exists as an add-on/top-up for services not covered under provincial health insurance or other group benefit plans sponsored by an employer. An HSA can be implemented on a stand-alone basis within a traditional benefit plan or as part of a flexible benefits plan.

How it works:

1. The plan is administered as a benefit by an employer (plan sponsor).
2. A plan sponsor decides how much to deposit in an employee's HSA for the year.
3. The employee (i.e., plan member) submits claims for healthcare expenses to be reimbursed from their HSA.
4. The insurer processes the claims according to the plan rules selected by the plan sponsor.
5. The plan member continues to submit claims until the HSA balance is zero, is no longer available for use or the benefit period has ended (which is often 12 months).
6. In some plans, carryovers are allowed into the next benefit period. There are two types of carryovers – credit carryover and claims carryover.
    - In a credit carryover, unused balance is brought forward to the next benefit period and often has to be used in a certain amount of time.
    - Claims carryover is when the balance for a benefit year is either zero or not available, and the claim in that period is carried forward and paid by the funds available in the next period.

Potential structure of the CDCP using OHSA

1. Based on modeling projections, using the 2025 CDCP government budget, the estimated cap for an OHSA per eligible Canadian who also participates in 2025 would be $563 (no private de-insurance) down to $450 (50% de-insurance rate). A reasonable cap would start at a $1000 minimum; therefore, this represents a significant shortfall. The expectation is that Canadians eligible for the CDCP would have high treatment needs the first couple of years.
2. One way to potentially address shortfalls, is if an OHSA could be structured in modules, the first module tier consisting of the most essential and needed care (with no balance billing), and then other module tiers introducing additional care but also allowing balance billing.
3. The annual caps can also be determined by age, with seniors over 65 and persons with disabilities getting a higher cap in the initial phases of the CDCP.

Advantages of HSA in the context of CDCP:

Potential benefits of OHSA: Dentists use customary fee guides, CDCP patient care is seamlessly integrated into current practice, patients have flexibility in choice of provider and treatment rendered and are thus very satisfied with care received, de-insurance risk mitigated to a greater extent, statistics are available that can be used to improve and modify plan.

1. Allows increased flexibility and more choice to user.
2. It can use existing claims and processing infrastructure thereby decreasing administrative burden.
3. Dentists can charge customary fees, and are much more likely to participate as program care providers.
4. Greater likelihood of de-insurance being mitigated.
5. Empowers patients to be more involved in their oral healthcare.

Drawbacks of HSA in the context of CDCP:

Potential drawbacks requiring mitigation strategies: accountability measures and controls, ensuring funds are spent on dentistry, potential administrative complications, inequitable benefit if same dollar amount is used across all provinces and territories.

1. Potential lack of accountability measures and controls as the patients can use funds as they see fit. Mechanism for cost-control may be needed.
2. Ensuring funds are actually spent on dentistry.
3. It may be administratively more complicated to operationalize if Health Canada does not have existing infrastructure in place.
4. It could be seen as inequitable if the same dollar amount is used across all provinces and territories.

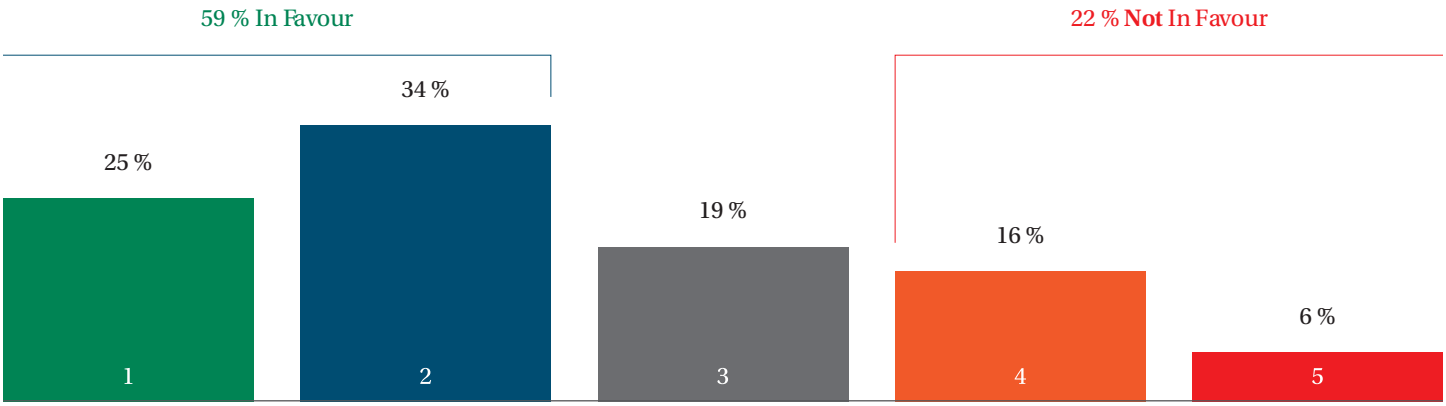
Public Support for an "Oral Health Spending Account" (OSHA) Concept

Abacus Data Public polling in February 2023 indicated that 3 in 5 (59%) Canadians support the federal government providing a dental spending account as part of the federal dental plan and many find it important to have autonomy when it comes to where, what treatments and the method of reimbursement when using the dental plan.

Question: To what extent are you in favour of the government providing a dental spending account through a federal dental plan or program? By this we mean you would be given a set amount of funds (if you are eligible) that you could spend on the treatment needs you and your dentist feel are most necessary.

3 in 5 Support the Government Providing a Dental Spending Account Through the Federal Dental Plan

1 = Highly In Favour
2 = In Favour
3 = Neutral
4 = Not In Favour
5 = Highly Not In Favour



To what extent are you in favour of the government providing a dental spending account through a federal dental plan or program? By this we mean you would be given a set amount of funds (if you are eligible) that you could spend on the treatment needs you and your dentist feel are most necessary.

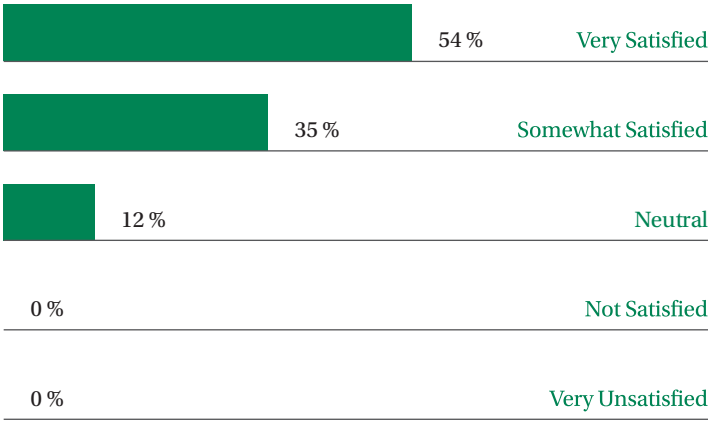
As well, 43% would be willing to pay extra for treatments not covered by the federal dental plan.

76% believe it is important or very important to have the ability to spend the money received from CDCP at a dentist/dental practice of one's choice and 71% believe it is important or very important to have choice over what treatments are to be covered.

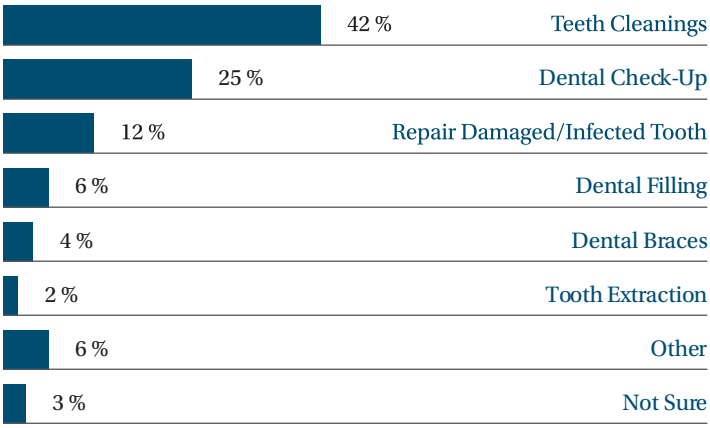
Additionally, the public is satisfied with the current Child Dental Benefit system, which is essentially a simplified version of an OHSA. 7 in 10 (71%) of those that received the benefit have so far received the dental treatment for their child(ren) – most likely for teeth cleanings and dental check-ups (the rest still waiting for care). Most (84%) were satisfied with the application and implementation process of receiving the benefit.

It is important to note that of those who received the CDB, the overwhelming majority were satisfied with the speed of receiving dental services. This demonstrates how quickly and efficiently care is received with a limited spending account ($650 per child), which can change significantly with a different reimbursement model.

Satisfaction with speed of recieving dental services:



As for dental services recieved, they seem to be appropriate and as expected:



A recent (March 2023) Health Canada commissioned public survey found similar results in terms of public usage and satisfaction with the Canada Dental Benefit. A total of 2,200 adult Canadians, aged 18 and older who met the eligibility criteria for the interim Canada Dental Benefit were surveyed and findings indicated that:

Source: Canada Dental Benefit Baseline Survey. Final Report. Prepared for Health Canada. The Strategic Council. March 2023. ISBN: 978-0-660-49335-0

- There are high levels of support for the Canada Dental Benefit (CDB), across the board – overall 87% of respondents support it and this does not vary significantly between those with/without insurance coverage. Almost two thirds (64%) strongly support the introduction of the interim CDB.
- Just under one quarter (23%) of those with no access to insurance say they have applied for the benefit and another 55% say they are planning to apply. Of note, 43% of those with insurance have also indicated they have either applied (9%) or are planning to (35%).
- A key motivator for those without insurance to apply for the program is the health of their family and children (51%).
- The main barriers to applying for the program, among those without insurance are varied and include: their child doesn't have urgent dental care needs (28%), believing they do not meet the eligibility criteria (27%), and that it still costs too much to get dental care (27%). Another 18% said the eligibility criteria are confusing or complicated.

OHSA: Comparable to Other Private Dental Plans

An OHSA would be better aligned with the concept that Canadians who access CDCP feel respected and empowered, with an active role in their oral health care. For example, eligible participants such as a low-income senior or child from a low-income family would be treated like all patients. All patients will be encouraged to form a trusted partnership with their dentist of choice and have agency and autonomy over their oral healthcare decisions. All people will receive the same attention and high-quality care that is provided to patients with private insurance and should have ready access to the necessary information and advice to make informed decisions about treatment options, risks, and benefits.

As a benchmark, considering the 2022 paid claims and employees covered of one of the federal employee public service plans:

Source: National Joint Council. Dental Care Plan Board of Management (NJC Part) - Annual Report – 2022

- The percent of covered employees at the end of 2022 who submitted at least one claim, either for themselves or an eligible dependant was 84.2%%.
- A total of 884,083 member claims were resolved, representing an increase of 8.2% over 2021 but 43.6% from 2020;
- The average cost per claim in 2022 increased by 0.7% to $177.68 from 2021 or by 4.2% from 2020.
- The average benefit per member in 2022 increased by 11%, to $985.37 from $961.78 (in 2021), which represents an increase of 2.5% or from $730.25 (in 2020) which represents an increase of 34.93%.
- Additionally, there has been a 10.5% increase in paid claims since 2019.

For 2022, the total amount charged by dentists to Plan members was $308,323,499 compared to $157,084,083 in net benefits paid to employees, for a reimbursement ratio of 50.9% (see Table 1).

Table 1

Breakdown of Paid Claims Plan Number 55555 - NJC 6-year Claims Processed Analysis

Year	Routine $	%	Major $	%	Ortho Amount $	%	Total Amount $
2017	92,526,067	81.6	10,281,966	9.1	10,545,054	9.3	**113,353,087**
2018	95,601,166	81.8	10,060,075	8.6	11,284,292	9.6	**116,945,533**
2019	104,120,814	81.3	11,474,634	9.0	12,467,706	9.7	**128,063,154**
2020	84,406,432	80.4	9,522,652	9.1	11,047,849	10.5	**104,976,933**
2021	115,629,048	80.2	13,104,366	9.1	15,429,241	10.7	**144,162,655**

Source: National Joint Council. Dental Care Plan Board of Management (NJC Part) - Annual Report - 2022

Variations between years 2017 and 2022, concerning paid claims by type of treatment, are as follows:

Table 2

Treatment	2017 %	2018 %	2019 %	2020 %	2021 %
Major Restorative	6.37	5.98	5.81	5.81	5.78
Minor Restorative	21.04	20.96	20.75	20.75	20.52
Oral Surgery	4.77	4.84	5.23	5.65	5.91
Orthodontic	9.30	9.65	9.74	10.52	10.70
Periodontic	24.87	24.96	25.00	24.11	24.97
Preventive	12.54	12.52	12.04	10.86	10.47
Adjunctive	1.21	1.23	1.40	1.49	1.58
Reline Rebase	0.02	0.02	0.02	0.02	0.02
Dentures	0.58	0.52	1.66	1.53	1.62
Diagnostic	13.63	13.79	13.50	13.93	13.59
Endodontic	3.55	3.41	3.35	3.60	3.15
Fixed Bridges	2.12	2.10	1.50	1.73	1.39
Total	**100**	**100**	**100**	**100**	**100**

Source: National Joint Council. Dental Care Plan Board of Management (NJC Part) - Annual Report - 2022

Out of these 884,083 member claims, 12% were submitted via paper, 79.5% were submitted by the provider and 8.5% were submitted online by the member. Overall, a total of 2,257,722 claims were handled, including dependant claims, representing an increase of 8.3% over 2021 and 40.9% from 2020.

The 2022 Annual Report indicates that the total cost for 2022 was $168.1 million and included $157 million or 93.4% for paid claims and $11.1 million or 6.6% for expenses. Of the $11.1million in expenses, claims settlement expense was $4,223,006, which is approximately 38% of all operating expenses and 2.5% of the total cost (National Joint Council. Dental Care Plan Board of Management (NJC Part) - Annual Report – 2022).

Looking at the typical service mix from dental claims data provides some high-level information on the distribution of funds of a potential OHSA, and how it can vary by age groups. This can help in setting various plan parameters.

CDAnet Claims Data:

Table 3

CDANet claims indicating the typical mix of services for the Canadian population with dental insurance (aged 65 and over):

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Distribution of Dentist Fees in Benefit Claims by Service Category for 2022 Population Aged 65 & Over

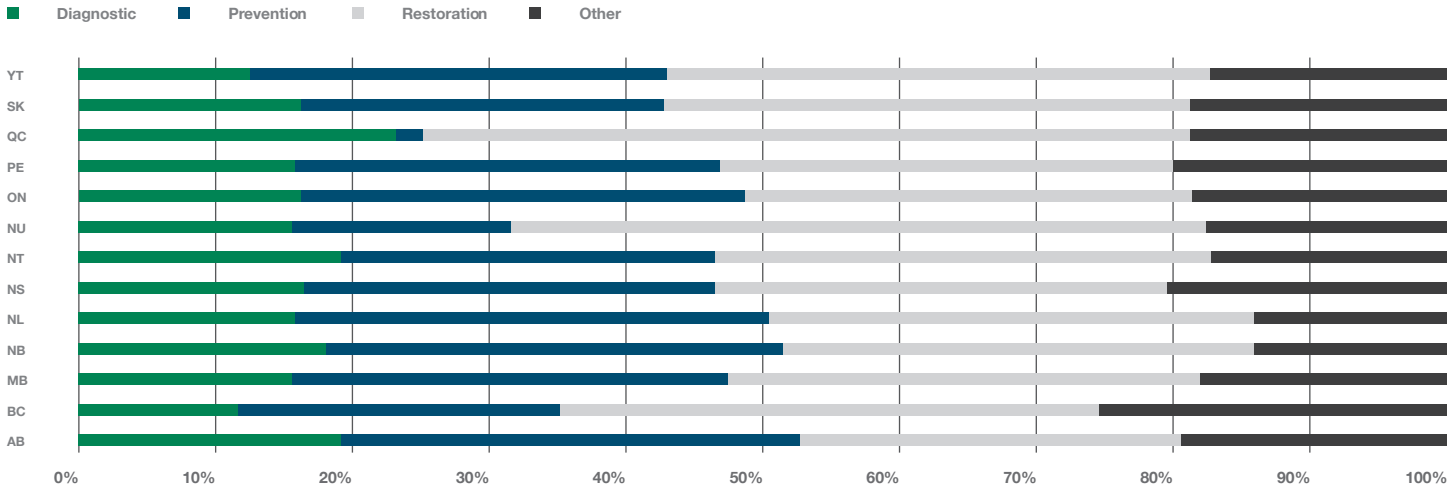

Table 4

CDANet claims indicating the typical mix of services for the Canadian population with dental insurance.

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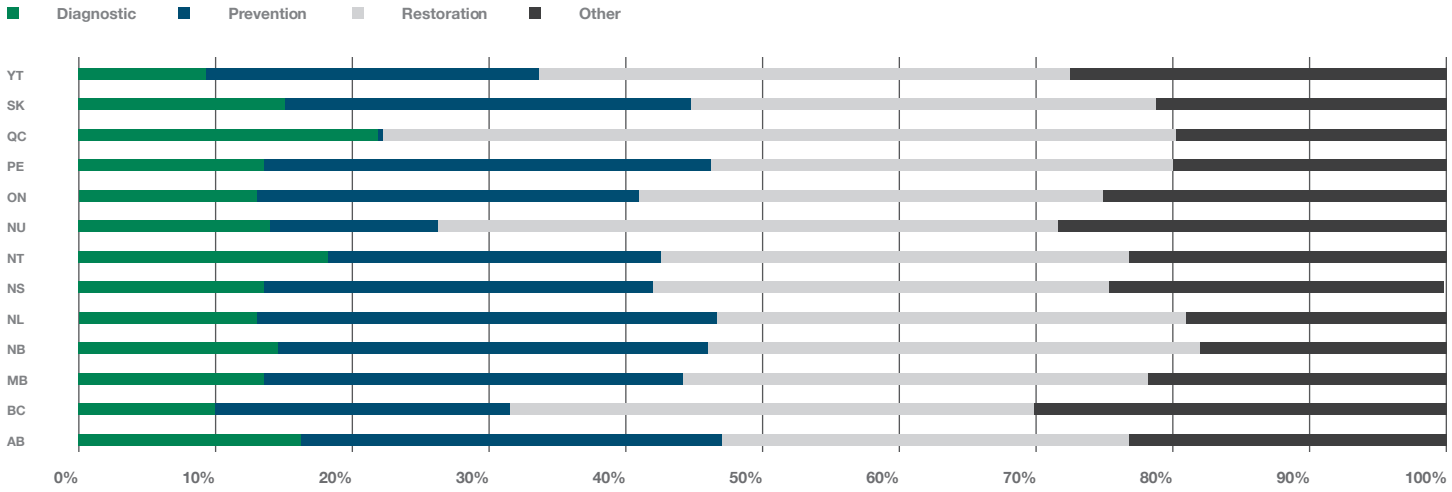
Distribution of Dentist Fees in Benefit Claims by Service Category for 2022 Population Aged 18 to 64



These are the types of services that should be expected from an OHSA.

Estimated Spending Limits for CDCP Users

$3,267 million was approved in the last budget for 2025 CDCP dental services. According to basic modeling projections, the table below shows estimated annual caps that would be available per eligible participant for an OHSA. The variability in fee guides across the country means that this is an average and not an amount that would be used for a provincial calculation.

Eligible Canadians who would also participate in 2025 Year	Caps for OHSA
5,806,000 (no private de-insurance)	$563
6,167,100 (25% de-insurance rate)	$530
7,253,700 (50% de-insurance rate)	$450

Features of an OHSA (Utilizing High-End Scenario Amount)

Categorization of services into various modules needs to consider both the need and cost for treatment, as in what would be first line treatment in case of emergency in first module and in normal circumstances progressively more expensive options depending on the module.

For an OHSA to be most efficient, balance billing could be permitted for dental services above the first module (emergency services), as well as pre-authorizations to go over the permitted amounts for dental services in higher modules. If balance billing is allowed then regardless of the option, the CDCP would be less restrictive in terms of service coverage at least for those who are willing and can pay for additional treatment. This could work for example if legislation for the CDCP specifies that no balance billing is permitted for emergency or essential services (thus allowing balance billing for services in the higher modules). This also ensures compliance with the requirement of no additional out-of-pocket payment for those below the threshold of family income. Plan design and what constitutes essential services and at what intervals is important, however restrictions based on service would significantly increase administrative burden.

If the OHSA was not used in its entirety in one year, the balance would be rolled into the following year. This would allow more costly procedures to be done in subsequent year.

Alternatively, and more practically, the OHSA could work in 2-year cycles based on $1126 bi-annually. Clearly this amount is not adequate when compared to the annual service use of those with private plans shown above (i.e., CDANet claims charts indicate relatively more restorative and other service usage, and these services cost significantly more than diagnostic/preventive services). Further, the average benefit per user of the federal public service plan was $961.78 in 2021, and that is with the use of premiums, deductibles and co-payments which serve as care rationing mechanisms.

Module 1	Emergency dental services
Module 2	Basic dental plan (could parallel Schedule A and Schedule B of NIHB)
Module 3	Additional services

First module available would be for emergency care. There would be no balance billing permitted. If additional funds greater than the $563 were needed, this would require a pre-authorization of additional funds.

Second module would be for basic dental care plan. If no emergency care was needed that year, all of this funding would be available for basic dental care. The treatment plan would be determined by the dentist/patient team taking into consideration previous dental work and more immediate needs. Some of these services could be deemed more essential than others.

Third module services could include dentures (for seniors), braces (for children) and more expensive services for low-income adults who choose services such as crowns, however this would need to be done with the allowance of balance billing, otherwise funding is not adequate.

A further step would be to cost this out for each province, which would show how a single amount across Canada may not work to provide people with these services without greater balance billing in some provinces than in others.

And going away from the discussion on fees and service coverage, another aspect with regards to OHSA is history of use. If patients have the freedom to choose their provider, then they may obtain additional treatments from different oral healthcare providers (dentists, dental hygienists, denturists, etc.). Further, dental hygienists and denturists have different procedure codes than dentists. Thus, there must be some mechanism for providers to be able to know the history of patients' care, who provided what treatment and provide care accordingly.

References:

1 Thompson B, Cooney P, Lawrence H, Ravaghi V, Quinonez C. Cost as a barrier to accessing dental care: findings from a Canadian population-based study. J Public Health Dent. 2014;74(3):210–8.

2 Hayes, A., Azarpazhooh, A., Dempster, L. et al. Time loss due to dental problems and treatment in the Canadian population: analysis of a nationwide cross-sectional survey. BMC Oral Health 13, 17 (2013). https://doi.org/10.1186/1472-6831-13-17.

3 Stewart, M., et al. (2000). "The impact of patient-centered care on outcomes." Journal of Family Practice 49(9): 796-804.

4 Tellez M, Gray SL, Gray S, Lim S, Ismail AI. A systematic review of the impact of access to dental care on oral health outcomes. Journal of Dental Education. 2013 Apr;77(4):416-30. doi: 10.1002/j.0022-0337.2013.77.4.tb05834.x.

5 J Can Dent Assoc 2019; 85:j3 at p 8

6 J Can Dent Assoc 2019; 85:j3 at p 2

7 Quinonez C, Gibson D, Jokovic A, Locker D. Emergency department visits for dental care of nontraumatic origin. Community Dent Oral Epidemiol 2009; 37: 366–371. See also Ontario Oral Health Alliance, Lack of access to dental care: The costs to our healthcare system, March 2019 https://www.allianceon.org/sites/default/files/documents/OOHA%20Fact%20Sheet%20ER%20and%20DR%20visits%20for%20dental%20problems%20March%202019.docx

8 Recent legislation implies that a person will be ineligible for the CDCP if that person can "access any dental care insurance, or coverage of dental services of any kind…" See section 4.1 of The Dental Care Measures Act, Division 29 of the omnibus 2023 Budget approval bill.

9 Cope, A., Chestnutt, I. The implications of a cost-of-living crisis for oral health and dental care. Br Dent J 234, 501–504 (2023).

10 Change in Dental Visit and Treatment Habits, Abacus Data, for the Canadian Dental Association, February 2023.

11 Ibid.

12 Quinonez, C., et al., Public preferences for seeking publicly financed dental care and professional preferences for structuring it. Journal of Community Dentistry and Oral Epidemiology, 2010. 38(2): p. 152-158.

13 Quiñonez, C.R., R. Figueiredo, and D. Locker, Canadian dentists' opinions on publicly financed dental care. Journal of Public Health Dentistry, 2009. 69(2): p. 64-73.

14 Quinonez, C., et al., Public preferences for seeking publicly financed dental care and professional preferences for structuring it. Journal of Community Dentistry and Oral Epidemiology, 2010. 38(2): p. 152-158.

15 Berman S., Dolins J., Tang S.-f., Yudkowsky B. Factors That Influence the Willingness of Private Primary Care Pediatricians to Accept More Medicaid Patients. PEDIATRICS. 2002;110(2):239–248.

16 Perloff JD, Kletke PR, Neckerman KM. Recent trends in pediatrician participation in Medicaid. Med Care. 1986;24(8):749–760.

17 Shen YC, Zuckerman S. The effect of Medicaid payment generosity on access and use among beneficiaries. Health Serv Res. 2005;40(3):723–744.

18 Cohen JW, Cunningham PJ. Medicaid physician fee levels and children's access to care. Health Aff (Millwood). 1995;14(1):255–262.

19 Shen YC, Zuckerman S. The effect of Medicaid payment generosity on access and use among beneficiaries. Health Serv Res. 2005;40(3):723–744.

20 Yoo BK, Berry A, Kasajima M, Szilagyi PG. Association between Medicaid reimbursement and child influenza vaccination rates. Pediatrics. 2010;126(5):e998–1010.

21 Healthy Smiles Ontario – Final Report, Ontario Dental Association, December 2017 (Study no. RXH5).

22 First Nations Health Authority, Briefing memorandum dated May 6, 2022 to The House of Commons Standing Committee on Indigenous and Northern Affairs re: Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program.

23 Data derived from the 2020/2021 Annual Report on the Non-Insured Health Benefits program: First Nations and Inuit Health Branch, published by Indigenous Services Canada.

24 Dental Benefits Guide for First Nations and Inuit: Non-Insured Health Benefits program, effective date: February 1, 2023.

25 Data derived from the 2020/2021 Annual Report on the Non-Insured Health Benefits program: First Nations and Inuit Health Branch, published by Indigenous Services Canada.

26 Based on analysis by the Canadian Dental Association.

27 First Nations Health Authority, Briefing memorandum dated May 6, 2022 to The House of Commons Standing Committee on Indigenous and Northern Affairs re: Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program.

28 First Nations Health Authority, Briefing memorandum dated May 6, 2022 to The House of Commons Standing Committee on Indigenous and Northern Affairs re: Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program.

29 First Nations Health Authority, Briefing memorandum dated May 6, 2022 to The House of Commons Standing Committee on Indigenous and Northern Affairs re: Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program.

30 First Nations Health Authority, Briefing memorandum dated May 6, 2022 to The House of Commons Standing Committee on Indigenous and Northern Affairs re: Study of Administration and Accessibility of Indigenous Peoples to the Non-Insured Benefits Program.

31 Standing Committee on Indigenous and Norther Affairs, 44th Parliament, 1st Session, Evidence no. 018, May 6, 2022.