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U.S. Department of Health and Human Services Releases Dental Plan Rates for Federally-Facilitated Health Insurance Marketplaces

On October 2, the U.S. Department of Health and Human Services released premium information for more than 17,000 plans across 36 states. These are the 36 states in which the federal government is operating federally-facilitated health insurance marketplaces. The data lists each plan by insurer, and the plan name and the monthly premium rate for a child, a 27-year-old, a 50-year-old, a family with 30-year-old parents and two children, a single-parent family with two children, and a 40-year-old couple without children.

Also, the plans are listed by descriptive tier (platinum, gold, silver or bronze) and detail how comprehensive the coverage is and what type of plan it is (HMO, PPO, etc.). For stand-alone dental plans, there are two-tiers: low (plans with actuarial values of 70%) or high (plans with actuarial values of 85%). The healthcare.gov website also allows users to search for plans by state and county.

For individuals and families, one table displays premiums for health insurance and a second table shows premiums for stand-alone dental plans. Also for small businesses, there are separate tables for health premium rates and rates for stand-alone dental plans.

California Finalizes Children’s Dental Plan Contracts for 2014

On September 13, Covered California, California’s health benefit exchange, announced that insurers signed contracts to offer pediatric dental coverage in 2014 in the exchange’s individual and small-group employer markets.

The contracts offer stand-alone plans for children’s dental coverage in the first year of the new health benefit exchange, which began open-enrollment on October 1. Additionally, California’s health benefit exchange pledged to work toward embedding pediatric dental coverage in its 2015 portfolio of comprehensive medical insurance products.

Five insurance companies will offer plans to families who buy insurance through Covered California in 2014: Anthem Blue Cross of California; Blue Shield of California; Delta Dental; Liberty Dental; and Premier Access. Seven companies will offer plans in Covered California’s Small Business Health Options Program (SHOP): Blue Shield of California, Delta Dental, Guardian, Liberty Dental, MetLife, Premier Access, and Safeguard. The companies offer a mix of plan choices statewide with rates as low as $8 per month in some areas.

Covered California dental benefit plans offer standard copayments, deductibles and coinsurance requirements. Unlike Covered California’s health insurance plans, dental plans are not designated by descriptive metal levels but come in two actuarial value options: an 85% plan, which features higher premiums but lower average out-of-pocket costs, and a 70% plan, with lower premiums and higher average out-of-pocket costs.

Because of technical constraints, Covered California is unable to offer bundled pediatric dental plans in 2014. This has led to Health Net’s withdrawal from participation in Covered California’s 2014 pediatric dental plans. To view an updated list of children’s dental insurance plan rates, click here.

January 1 Deadline Approaches for 21 States to Shift Children from the Children’s Health Insurance Program to Medicaid

Beginning January 1, 2014, Medicaid must cover children, ages six to eighteen, with incomes up to 133% of the federal poverty level (FPL) ($31,322 for a family of four in 2013). Today, states must cover children under the age of six in families with incomes of at least 133% of the FPL in Medicaid, while
children ages six to eighteen with incomes above 100% of the FPL ($23,550 for a family of four in 2013) may be covered in separate state Children’s Health Insurance Programs or Medicaid at the state’s option. Although many states cover children in Medicaid with income up to 133% of the FPL, due to the change in law, 21 states needed to transition some children from the Children’s Health Insurance Program (CHIP) to Medicaid.

This split source of coverage for children is commonly referred to as “stairstep” eligibility, where different aged children in the same family are being enrolled in different coverage programs with different benefits, provider networks, renewal procedures, etc. When the Affordable Care Act (ACA) was enacted 21 states had stairstep eligibility: Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Kansas, Mississippi, Nevada, New Hampshire, New York, North Carolina, North Dakota, Oregon, Pennsylvania, Tennessee, Texas, Utah, West Virginia, and Wyoming. The Henry J. Kaiser Family Foundation estimates that 562,103 children will be impacted by the transition, with the largest numbers coming from Texas (131,070 children), Florida (71,329 children), and Georgia (59,435 children). On August 9, the Centers for Medicare and Medicaid Services issued a FAQ document to assist states tackling stairstep eligibility (view the FAQs beginning on question #10).

States will continue to discuss whether to continue CHIP in the future, as the ACA extends funding for CHIP only through FY15 and continues the authority for the program through 2019.

**U.S. Department of Health and Human Services Approves Arkansas’ Private Option for Medicaid Expansion**

On April 23, Gov. Mike Beebe (D-AR) signed into law the Arkansas private option bills (S.B. 1020 and H.B. 1143) that will provide health insurance for 250,000 Arkansans. The law allows Arkansas to accept federal Medicaid funds and use those funds to pay for private insurance for certain adults newly eligible for Medicaid under the Affordable Care Act (ACA) Medicaid expansion provisions. However, at that time the governor still needed to submit a Medicaid waiver application and receive approval from the U.S. Department of Health and Human Services (HHS).

On September 27, the HHS Secretary Kathleen Sebelius contacted Gov. Beebe to inform him that HHS approved the state’s Medicaid waiver request. The waiver allows the state to move forward with the Health Care Independence Program (the official name of the private option). According to the 1115 waiver application, Arkansas will use premium assistance to purchase qualified health plans (QHPs) offered in the individual market through the marketplace for individuals eligible for coverage under Title XIX of the Social Security Act. Eligible individuals are either: (1) childless adults between the ages of 19 and 65 with incomes at or below 138% of the federal poverty level (FPL) who are not enrolled in Medicare or incarcerated, or (2) parents between the ages of 19 and 65 with incomes between 17% and 138% FPL who are not enrolled in Medicare or incarcerated (collectively private option beneficiaries). Private option beneficiaries will receive the Alternative Benefit Plan (ABP) through a QHP that they select and have cost-sharing obligations consistent with both the state plan and with the cost-sharing rules applicable to individuals with comparable incomes in the marketplace.

Additionally, Arkansas will provide wrap-around benefits through its fee-for-service Medicaid program. These benefits are required for the ABP but not covered by QHPs—namely, non-emergency transportation and Early Periodic Screening Diagnosis and Treatment (EPSDT) services for individuals participating in the demonstration who are under age 21 (including pediatric vision and dental services, as well as other EPSDT services to the extent such services are not covered under the QHP).

As you recall, in response to growing state interest in providing private health insurance to those persons eligible to receive services under the ACA Medicaid expansion provisions, the Centers for Medicare & Medicaid Services (CMS), within HHS, released a memorandum on March 29, defining and explaining the limitations on using premium assistance for private coverage in Medicaid.
It is important to note that Indiana, Iowa, Michigan, and Pennsylvania are also pursuing alternative Medicaid expansion plans. Currently, 20 states and the District of Columbia have indicated that they plan to expand their traditional Medicaid program under the ACA. However, now that Arkansas has received federal approval to move forward with the private option, more states may follow its lead.

**National Governors Association Releases Report on Effectiveness of Post-Secondary Institutions**

On September 19, the National Governors Association (NGA) released a report that governors can use as a tool to help them evaluate the effectiveness and efficiency of the colleges and universities in their state. The report, titled *Beyond Completion: Enabling Governors to Evaluate the Outcomes of Postsecondary Education*, notes that governors are asking four fundamental questions about the effectiveness and efficiency of investments in their states’ postsecondary educational institutions and systems, in order to develop their policy agendas:

**Effectiveness**
- Are our postsecondary students learning the knowledge and skills needed to be successful workers and citizens?
- Do our postsecondary graduates get jobs, and do those jobs pay wages and salaries that can support families?

**Efficiency**
- How does the number of students who graduate from our postsecondary institutions compare with the number of students who enroll?
- What is the return on our states’ and our students’ investments in postsecondary education in terms of completed degrees and certificates?

The NGA report also provides specific examples of indicators that postsecondary leaders can use to provide answers to the four fundamental questions listed above.

As states face fiscal pressure in areas such as health care and pensions, their ability to invest in postsecondary education will be at risk. As a result, systems of postsecondary education must be prepared to show how productive colleges and universities are with their existing resources and look for ways to improve their effectiveness and efficiency, according to the NGA report.

**State Ballot Measures Up for Vote in November**

According to the National Conference of State Legislatures (NCSL), voters in six states will consider 31 ballot measures on November 5. Three of the six states have measures on their ballots that are of interest to the dental education community.

**Maine**

There are two ballot measures in Maine that would increase funding for the University of Maine System and the Maine Community College System:

- Question 2 states, “Do you favor a $15.5 million bond issue to enhance educational and employment opportunities for Maine citizens and students by updating and improving existing laboratory and classroom facilities of the University of Maine System statewide?”
- Question 5 states, “Do you favor a $15.5 million bond issue to upgrade buildings, classrooms and laboratories on the seven campuses of the Maine Community College System in order to increase capacity to serve more students through expanded programs in health care, precision machining, information technology, criminal justice and other key programs?”
Texas

On May 14, H.J.R. 79 passed both chambers and was filed with the Texas Secretary of State. H.J.R. 79 eliminates a requirement for a State Medical Education Board and a State Medical Education Fund, and puts the issue up for vote during the next general election.

According to the author of the bill, Rep. Dan Branch (R-TX), a Legislative Budget Board (LBB) performance report issued to the legislature in the mid-1980s found the success of the State Rural Medical Education Board (since renamed the State Medical Education Board) questionable and recommended that the board be abolished. The LBB found that only a small percentage of the people who had received loans administered by the board were practicing medicine in rural Texas counties, with only a slightly larger percentage of those individuals practicing in areas designated as medically underserved. According to Rep. Branch, no new loans have been made by the board in more than 25 years, and the board currently has no appointees and receives no program funding.

**Proposition 2** states, “The constitutional amendment eliminating an obsolete requirement for a State Medical Education Board and a State Medical Education Fund, neither of which is operational.”

Washington

In 2007, Initiative Measure No. 960 was passed by voters. The measure required two-thirds legislative approval or voter approval for tax increases, legislative approval of fee increases, certain published information on tax-increasing bills, and advisory votes on taxes enacted without voter approval. As a result of the 2007 measure, any tax extension is deemed a tax increase and those taxes enacted without voter approval must appear on election ballots as advisory votes. According to staff at the Office of the Secretary of State in Washington, advisory votes do not change the law, but instead are essentially notices to the state legislature that the public either agrees or disagrees with the legislature’s action.

According to the Office of the Secretary of State in Washington, section 3(6)(c) of **H.B. 1846** removes the exemption for pediatric oral services offered as essential health benefits outside the Washington Health Benefit Exchange. Since these services have previously been exempted, this will result in additional revenue for the insurance premium tax. However, the amount of taxable activity resulting from pediatric oral health care services benefits cannot be estimated. Consequently, the amount of additional revenue attributed to pediatric oral services offered as essential health benefits outside the Health Benefit Exchange is indeterminate.

**Advisory Vote No. 5** states, “The legislature extended, without a vote of the people, the insurance premium tax to some insurance for pediatric oral services, costing an amount that cannot currently be estimated, for government spending. This tax increase should be: repealed or maintained.”

State Policy Updates

- **Oregon**

  On June 26, Gov. John Kitzhaber (D-OR) approved **S.B. 2**. The law establishes the Scholars for a Healthy Oregon Initiative to be administered by the Oregon Health and Science University pursuant to rules adopted by the university. The university was given $2.5 million to administer the initiative. The initiative provides a full scholarship for students pursuing a degree in a health profession. The law requires the university to give preference when awarding these scholarships to prospective health care practitioners who are: (a) from rural heritage, as defined by the university’s admission

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1 Specifically, 3(6)(c) of H.B. 1846 provides for the continuation of preferential tax treatment for pre-paid dental insurance plans. Whereas health insurers must pay a 2% premium tax to the state, dental insurance carriers will pay a 1.5% tax on all dental benefit prepayments.
policy; (b) first generation college students; or (c) individuals from a diverse or underrepresented community. The law also entails a service requirement. Immediately upon the prospective health care practitioner’s completion of the health care education degree, residency or training, the participant must practice as a health care practitioner in a designated service site in Oregon approved by the university for one year longer than the number of years the participant spent in the health care program for which the participant received a scholarship.

- **Vermont**

On May 26, 2011, Gov. Peter Shumlin (D-VT) signed H. 202 (now called Act 48). Act 48 created the Green Mountain Care Board (GMCB) to guide transitions in Vermont’s health system. It not only establishes Vermont’s health insurance marketplace in alignment with the Affordable Care Act but goes even further. By 2017, or when federal waivers allow, Vermont intends to launch a new system called Green Mountain Care. This new system will allow all Vermonters to have health coverage through a single system providing universal health care. According to the GMCB, “of every dollar Vermonters spend on any kind of goods or services, 20 cents goes to health care. By comparison, the U.S. as a whole spends 17 cents of each dollar on health care, while other developed nations tend to spend only half that much.” The GMCB is uniquely positioned to provide oversight for major factors influencing health care costs, such as hospital budgets, health insurance rates, benefit decisions and major expenses, rates paid by insurance companies and Medicaid, and plans to ensure Vermont has enough health professionals to serve its residents. However, the governor’s office will ultimately be responsible for planning, developing and implementing the new system.

**Dental Program Spotlight: Georgia**

The Oral Health Center at Grady Health System’s Infectious Disease Program in Atlanta, Georgia, provides free comprehensive dental care (with the exception of implants and some third molar extractions) for its residents diagnosed with HIV/AIDS. The center is primarily funded by the Ryan White HIV/AIDS Program. The Ryan White legislation created a number of programs (called Parts) to meet the needs of different communities and populations affected by HIV/AIDS. The various programs are divided among Parts A-F. Part A provides emergency assistance to eligible metropolitan areas and transitional grant areas that are most severely affected by the HIV/AIDS epidemic. Funds from all Ryan White HIV/AIDS grant programs can support the provision of oral health services. However, two programs specifically focus on funding oral health care for people with HIV and both fall under Part F: the Dental Reimbursement Program (DRP) and the Community-Based Dental Partnership Program (CBDPP).

For FY13 the Oral Health Center at Grady Health System’s Infectious Disease Program in Atlanta, Georgia, received $1,003,500 under Part A to cover salaries, lab costs, and dental supplies. The center will receive an additional $350,000 per year from the Georgia AIDS State grant, a line item in the Georgia state budget, to provide dental care for approximately 2,000 people living with advanced HIV disease.

The staff of the Oral Health Center is made up of five dentists, four dental hygienists and five dental assistants. In addition, four Advanced Education in General Dentistry (AEGD) residents rotate through the center.

**Residents Served:**

Below is the demographic data of all patients who obtain care in the Infectious Disease Program. The Oral Health Center’s demographic data closely mirror the population as a whole.
2012 (actual CY12)

<table>
<thead>
<tr>
<th>Age</th>
<th># (%) Male</th>
<th># (%) Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – &lt;2 yr</td>
<td>174 (3.28%)</td>
<td>80 (1.51%)</td>
</tr>
<tr>
<td>2-12 yrs</td>
<td>121 (2.28%)</td>
<td>60 (1.13%)</td>
</tr>
<tr>
<td>13-24 yrs</td>
<td>378 (7.12%)</td>
<td>141 (2.66%)</td>
</tr>
<tr>
<td>25-44 yrs</td>
<td>2,100 (39.54%)</td>
<td>544 (10.24%)</td>
</tr>
<tr>
<td>45-64 yrs</td>
<td>2,416 (45.50%)</td>
<td>598 (11.26%)</td>
</tr>
<tr>
<td>&gt;65 yrs</td>
<td>121 (2.28%)</td>
<td>41 (0.77%)</td>
</tr>
</tbody>
</table>

In 2012, the Oral Health Center served approximately 2,000 patients. To view individual state-level information on the Ryan White HIV/AIDS Program, click here.

Reports of Interest

The Robert Wood Johnson Foundation (RWJF) released three oral health reports. Researchers commissioned by the RWJF examined 25 programs that addressed barriers to preventive oral health services with solutions in non-traditional, community and mobile settings. The reports below culminate a two-year collaborative effort led by a team from RWJF and consultant ICF International.

- **Dental Professionals in Non-Dental Settings** ([report](#))
  The report evaluates nine programs that seek to increase access to preventive oral health care in non-dental settings, such as senior centers, schools and Head Start sites. Each program works to expand the dental workforce by training new types of providers.

- **Providing Preventive Oral Health Care for Infants and Young Children in Women, Infants, and Children (WIC), Early Head Start, and Primary Care Settings** ([report](#))
  The report evaluates seven oral health programs that provide preventive oral health care to young children (infants, toddlers, and children up to 5 years old) in Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), Early Head Start (EHS), and primary care settings. All of the programs strive to increase access to preventive oral health care by integrating dental services into primary care settings, WIC clinics, or EHS centers.

- **Innovations that Address Socioeconomic, Cultural, and Geographic Barriers to Preventive Oral Health Care** ([report](#))
  The report evaluates nine programs seeking to increase the number of children from low-income families who receive preventive oral health care, and to encourage families and communities to prioritize oral health. Two of the programs evaluated incentives for providers to see more Medicaid-eligible clients; seven established new clinics and mobile units, some staffed by dental hygienists; and eight programs identified Medicaid-eligible children through Head Start and social service agencies.

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2 The Center manages patients who live in the 20 county Ryan White Part A metropolitan statistical area (MSA).
The University of North Carolina at Chapel Hill released a report on 17 states\(^3\) that could serve as policy laboratories to provide federal and state policymakers with a range of innovative ideas about how to reform graduate medical education (GME) policy, governance and finance. While the study revealed numerous instances of successful attempts to reform GME, no single state employed innovative approaches in all four study aims.\(^4\) However, the report offered recommendations to state policymakers as they continue to address GME funding. Recommendations included the following: states should create a GME advisory entity that promotes discussion, coordination and education about GME; all payer, third-party payer, Medicaid and state appropriations for GME need to be carefully considered and designed to be responsive to the state’s population health needs; and new GME funding should be tied to performance metrics and require monitoring about how funds are spent.

Health Affairs and the Robert Wood Johnson Foundation released an issue brief providing details on the new excise tax on high-cost health plans proposed to both slow the rate of growth of health costs and finance the expansion of health coverage under the Affordable Care Act. The provision is often called the "Cadillac" tax because it targets so-called Cadillac health plans that provide employees the most generous level of health benefits. These high-end health plans' premiums are mostly paid for by employers. In addition, the plans have low, if any, deductibles and little cost sharing for employees.

The U.S. Department of Health and Human Services, Office of Inspector General issued a report finding that the 12 states that volunteered to work with the Centers for Medicare and Medicaid Services had made little progress in implementing the Transformed Medicaid Statistical Information System (T-MSIS). T-MSIS is designed to be a detailed national database of Medicaid and Children’s Health Insurance Program information to cover a broad range of user needs, including program integrity.

The Kaiser Commission on Medicaid and the Uninsured issued a report surveying the Medicaid budgets for all 50 states and the District of Columbia. The report found that improvements in the economy resulted in modest growth in Medicaid spending and enrollment in FY13. States moving forward with the Medicaid expansion are expected to see higher enrollment and total spending growth driven by increases in coverage and federal funds. Additionally, according to the report, the implementation of the Affordable Care Act (ACA) will result in major changes to Medicaid eligibility and enrollment for all states, whether they are implementing the ACA Medicaid expansion or not.

Trust for America’s Health released a report finding that 28 states and the District of Columbia scored six or less out of 10 possible indicators of promising strategies to help curb prescription drug abuse. Two states—New Mexico and Vermont—achieved the highest score, receiving all 10 possible indicators, while South Dakota scored the lowest with only two. According to the report, prescription drug related deaths now outnumber those from heroin and cocaine combined, and drug overdose deaths exceed motor vehicle-related deaths in 29 states and the District of Columbia. To view state-by-state prescription drug overdose death rates and learn how your state scores on the 10 key steps to curb abuse, click here.

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3 The 17 states studied include: California, Florida, Georgia, Illinois, Maryland, Massachusetts, Michigan, New Jersey, New York, North Carolina, Tennessee, Texas, Utah, Vermont, and WWAMI states (which include Washington, Wyoming, Alaska, Montana, and Idaho). The latter 4 states have an agreement whereby they send students to the University of Washington, which serves as a public medical school for all 5 states. According to the report, researchers did not interview any experts from Alaska or Wyoming for the study, but did interview WWAMI experts who were familiar with GME policies and programs in all 5 states.

4 The objectives of this study were to examine the extent to which states have, or plan to: 1) use health workforce data to assess residency training needs; 2) implement novel GME financing initiatives, including all payer systems; 3) create governance structures to allocate GME positions between specialties, geographies and training sites; and 4) establish policies or measures to encourage accountability of public funds invested in GME.
ADEA United States Interactive Legislative Tracking Map

For additional information on state legislation affecting academic dentistry, please visit the ADEA United States Interactive Legislative Tracking map. The map is updated daily and will allow members to view:

- The current status of bills,
- Upcoming hearing dates, and
- Current bill text and bill author/sponsor information.

For those states whose legislative sessions have adjourned “sine die,” the bills listed have been either signed by the governor or they have automatically become law without the governor’s signature. Users will be able to see the effective date of the legislation, unless the bill has been vetoed. As new bills relevant to academic dentistry are introduced, the bills will be added to the map. To use the interactive map, visit www.adea.org/legislativemap.

ADEA AGR Twitter Account

For additional information on issues affecting academic dentistry and dental and craniofacial research in Congress, federal agencies and state legislatures, please follow ADEA Advocacy and Government Relations on Twitter at ADEAAGR; there is much to “tweet” about.

ADEA/Sunstar Americas, Inc./Harry W. Bruce, Jr. Legislative Fellowship

Dental school faculty members or administrators who want to interface with members of Congress on issues of importance to oral health are encouraged to apply for the ADEA/Sunstar Americas, Inc./Harry W. Bruce, Jr. Legislative Fellowship. The fellow selected spends three months in Washington, D.C., working on issues and policies that could make a difference in the life of every American. This public policy fellowship coincides with congressional consideration of the federal budget and other legislative and regulatory activities important to dental education and research. The fellow functions as an ADEA Policy Center staff member who works within the AGR portfolio on ADEA’s specific legislative priorities. The fellow’s responsibilities may include drafting policy, legislative language, position papers and testimony; educating members of Congress and other decision makers on matters of importance to dental education; and participating in gatherings of various national coalitions. The fellow receives a taxable stipend of $15,000 to cover travel and expenses for approximately three months (cumulative) in Washington, D.C. (ADEA is flexible in the arrangement of time away from the fellow’s institution.) The fellow’s institution continues to provide salary support for the duration of the experience. Since its inception in 1985, the ADEA/Sunstar Americas, Inc./Harry W. Bruce, Jr. Legislative Fellowship has been generously underwritten by Sunstar Americas, Inc. Interested candidates should apply as soon as possible.

ADEA/Sunstar Americas, Inc./Jack Bresch Student Legislative Internship

The ADEA/Sunstar Americas, Inc./Jack Bresch Student Legislative Internship is a six-week, stipend-supported internship in the Advocacy and Governmental Relations portfolio of the ADEA Policy Center (ADEA AGR) in Washington, D.C. This student legislative internship provides a unique learning experience for predoctoral, allied and advanced dental student residents and fellows. It is designed to encourage students to learn about and eventually—as dental professionals—to become involved in, the federal legislative process and the formulation of public policy as it relates to academic dentistry. It is open to any predoctoral, allied or advanced dental student resident or fellow who is interested in learning about and contributing to the formulation of federal public policy with regard to dental education, dental research and the oral health of the nation. Funded through the generous support of Sunstar Americas, Inc., the student intern will be a member of the ADEA AGR staff and will
participate in congressional meetings on Capitol Hill, coalition meetings and policy discussions among the ADEA Legislative Advisory Committee (ADEA LAC) and ADEA AGR staff.

An applicant must be a full-time predoctoral, allied or advanced dental student, resident or fellow whose institution is willing to work with the student to identify an appropriate time, consisting of six weeks, during the school year to pursue the internship. For additional information, please email Yvonne Knight, J.D., ADEA Senior Vice President for Advocacy and Governmental Relations, at KnightY@ADEA.org. Applications are accepted on a year-round basis.

The ADEA Policy Center publishes the *ADEA State Update* monthly. Its purpose is to keep ADEA members abreast of state issues and events of interest to the academic dental and research communities.

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