

**Health Care Reform Legislation: Side-by-Side Comparison**

**November 24, 2009**

Issues	<p><b>“Affordable Health Care for America Act” H.R. 3962 House-Passed Version -- Nov. 7, 2009</b></p>	<p><b>“Patient Protection and Affordable Care Act” As Introduced in Senate on Nov. 18, 2009 (amended in the nature of a substitute to H.R. 3590)</b></p>	<p><b>ADA Comments/ Amendments</b></p>
<p><b>Creation of an Entity to Regulate the Private Insurance Market; the Government Run Insurance Plan; Consumer Protections; Impact on Stand Alone Dental Plans</b></p>	<p>Individuals and small employers (beginning with firms with 25 employees in 2013; 50 employees in 2014; and 100 employees in 2015) will be able to purchase “qualified” private coverage (“Qualified Health Benefits Plans” (QHBP)) through a <i>National Health Insurance Exchange</i>. States and territories will have the option to run their own Exchange if federal standards are met. The Exchange serves as a pooling mechanism for offering private coverage (and a public insurance plan). It is also the mechanism used to administer the tax credits and for enforcing the variety of requirements placed on QHBPs. (Sec. 222; pages 104-111; Sec. 301-311; pages 155-211)</p> <p>The plans will be subject to a variety of <b>market reforms</b>, such as prohibition of pre-existing conditions, guarantee issue, premium rating limits, ensuring adequacy of provider networks, requiring to offer dependent coverage for uninsured young adults (under 27 years of age), etc. (Sec. 211-217; pages 95-102)</p> <p>QHBP shall establish <b>consumer protections</b>,</p>	<p>Individuals and small employers (not more than 100 employees) will be able to purchase qualified health plans (QHPs) through a <i>state run American Health Benefit Exchange</i> by January 1, 2014, except in plan years before 2016 a state may limit access to the Exchange to employers with no more than 50 employees. Large employers may be allowed into the Exchange beginning in 2017. The Exchange must also provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to help small employers to enroll their employees in QHPs. An Exchange may operate in more than one state with approval from affected states and the Secretary and a state may establish subsidiary Exchanges within the state to serve geographically distinct areas, for example. (Sec. 1304; page 126; Sec. 1311; pages 128- 154)</p> <p><b>Immediate market reforms and consumer protections</b> include no lifetime or annual limits, prohibition on rescissions (except for</p>	<p>ADA policy (Res. 60H) passed by the 2009 House of Delegates states the Association shall advocate for any health care reform proposal that maintains the private health care system and assures that insurance coverage is affordable, portable and available without regard to preexisting health conditions. ADA policy (Res. 33H) passed by the Association’s 2009 House of Delegates also directs the ADA to seek application of consumer protections that would apply to ERISA plans that are exempt from state consumer protection laws. ADA policy (Res. 59H) passed by the 2009 House of Delegates states the Association shall advocate for any health care reform proposal that opposes any third party contract provisions that establish fee limits for non-scheduled dental services.</p> <p>The ADA would oppose a <b>government run insurance plan</b> (the public option plan) that:</p> <ul style="list-style-type: none"> <li>• required health care providers to participate,</li> <li>• directly or indirectly dictated fees for the private market,</li> </ul>

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	<p>including fair grievance and appeals mechanisms, information transparency and plan disclosure, timely payment of claims, standardized rules for coordination and subrogation of benefits, and application of administrative simplification. (Sec. 231-237; pages 119-127)</p> <p>The Exchange will also offer a <b>public insurance plan option</b>. The Secretary will negotiate fees with providers who choose to participate in the public option plan (providers will be able to opt out of the plan). Aggregate payment rates in the public plan may not be lower than rates under Medicare or higher (in the aggregate) than the average rates paid by other qualified health benefit plans (the private sector plans) in the exchange. (Sec. 321-331; pages 211-225)</p> <p>Each territory, <b>including Puerto Rico</b>, may elect to participate in the Exchange and is provided funds for affordability credits if the territory adopts the reforms and requirements for individual and employer responsibility in the bill. (See Sec. 100;</p>	<p>fraud or misrepresentation), extension of dependent coverage to age 26, required coverage for prevention, an appeals process, uniform explanation of coverage documents and standardization of definitions, required premium refunds if non-claims costs exceed 20 percent (group market) or 25 percent (individual market). (Sec. 2711-2719; pages 16-34) Effective 2014, additional <b>market reforms</b> include prohibition of pre-existing conditions, guarantee issue and renewability, premium rating limits, non-discrimination based on health status, non-discrimination based on degree of provider. (Sec. 2701-2708; pages 78-97)</p> <p>The Exchange will offer a <b>public insurance option plan</b> (called the community health insurance option) -- unless the state enacts a law to opt out. Requires the public option to cover only essential health benefits; state must defray cost of additional benefits beyond essential. Nothing requires a provider to participate. The Secretary will negotiate fees with providers who choose to participate but rates cannot be higher, in aggregate, than the average QHP’s reimbursement rates. The consumer protection laws of the state shall apply. (Sec. 1323, pages 182-188)</p> <p>Each territory, <b>including Puerto Rico</b>, will receive a 30 percent increase in Medicaid</p>	<ul style="list-style-type: none"> <li>• would lead to a government-run health system, and</li> <li>• did not use market billed rates to determine the fee payments for providers.</li> </ul> <p>Consumers, including dental patients, deserve <b>insurance protections</b> that ensure health care value and transparency.</p> <ul style="list-style-type: none"> <li>• <b>Plans should not be allowed to limit payment on services not covered by the plan.</b></li> <li>• Consumers should have uniform coordination of benefits to permit 100 percent payment of a claim.</li> <li>• Consumers should receive timely payment of claims.</li> <li>• Consumers who choose to do so should be able to assign their benefit to their dentist.</li> <li>• Insurance terms should be written in plain language.</li> </ul>

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	<p>page 16 for general authority)</p> <p><b>Stand-alone dental plans</b> will not be able to participate in the Exchange. A provision expressly states that QHBPs may subcontract with stand-alone plans for the provision of dental, vision, mental health, and other benefits. (Sec.100, pages 9 and 11; Sec. 221; page 104)</p>	<p>payments beginning with fiscal year 2011 and enhanced federal matching funds for mandatory expanded enrollment of adults. (Sec. 2005; pages 430-432)</p> <p><b>Stand-alone dental plans</b> are permitted to operate in the Exchange either separately or in conjunction with a medical plan if the dental plan provides the required children’s oral health coverage required of all QHPs. (Sec. 1302, page 106-107; Sec. 1311, pages 136-137)</p> <p>Unlike the House bill –</p> <p>Participation by qualified individuals in the Exchange is voluntary. An individual may enroll in any plan – in or outside the Exchange – but all insurance issuers in the individual or small group market must ensure coverage includes the “essential health benefits package”, which includes oral care for children. Plans offered by the federal government to Members of Congress and staff must be offered through the Exchange or through a health plan created under this Act. (Sec. 1312, pages 153-156; Sec. 1302, page103)</p> <p>There is a Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit health insurance issuers to compete with the other plans. (Sec. 1322,</p>	<p>Regarding <b>stand alone dental plans</b> – the ADA worked with Senator Stabenow (D-MI) who successfully amended the Senate Finance Committee’s version of health care reform legislation to permit stand-alone dental plans into the Exchange, which also ensures ERISA-regulated consumer protections apply to the stand-alone dental plans. The ADA is continuing to lobby for a similar provision in H.R. 3962, including consumer protections that would <b>not allow dental plans to limit payment on services not covered by the plan.</b></p>

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		<p>pages 168-182)</p> <p>For low-income individuals who are not eligible for Medicaid (with household income from 134 percent to 200 of the federal poverty level), states are given flexibility to offer “standard health plans” tailored to the needs of such populations instead of offering coverage through the Exchange. (Sec. 1331, pages 201-212)</p>	
<b>Antitrust Issues</b>	<p>This provision restores application of federal antitrust laws to the business of health insurance and the business of medical malpractice insurance. This provision does not apply to activities concerning loss data and performing actuarial services if doing so does not involve restraint of trade. (Sec. 262; pages 150-153; see also Sec. 260, page 149 regarding FTC authority)</p>	<p>A section in the bill expressly states the antitrust laws are not affected by the bill. (Sec. 1560, page 371)</p> <p>There is a possibility of a floor amendment from Senator Leahy.</p>	<p>The ADA is on record supporting the provision in H.R. 3962, which essentially repeals the McCarran-Ferguson Act.</p> <p>The ADA has actively lobbied in support of an amendment of the health care reform legislation to repeal the McCarran-Ferguson federal antitrust exemption for the “business of insurance” because it would boost competition in the health care marketplace.</p> <p>The ADA is also on record supporting several pieces of legislation that would repeal the McCarran-Ferguson federal antitrust exemption for the health insurance industry, including “The Insurance Industry Competition Act of 2009” (H.R. 1583) and the “Health Insurance Industry Antitrust Enforcement Act of 2009” (H.R. 3596), as well as their companion bills in the Senate.</p>

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<p><b>Benefit Packages Offered in Exchange</b></p>	<p>All Qualified Health Benefits Plans (QHBP) must provide an essential health benefits package that includes preventive services recommended by the United States Preventive Services Task Force. The QHBP essential health benefits package must also include <u>oral health for children</u> younger than 21 years of age. The scope of the oral health benefits will be defined by the Health Benefits Advisory Committee, which is a public-private advisory body (which must include <b>dental experts</b>) that will make recommendations on changes to the essential benefits package and cost sharing levels. There will be no cost-sharing for preventive services and there are limits on annual cost-sharing based on level of income. (Sec. 222-223; pages 104-116)</p> <p>In addition, premium-plus plans within the Exchange program may offer <b>adult oral health coverage</b>. (Sec. 303; page169)</p> <p>There is a requirement that no later than one year after enactment, the Secretary shall submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable <b>oral health care to adults</b> as part of the essential benefits package. (Sec. 222; page 111)</p>	<p>All Qualified Health Plans (QHPs) must provide an essential health benefits package as defined by the Secretary – but which shall include <u>pediatric oral care</u>, limits cost-sharing and has a specified actuarial value. There are bronze, silver, gold, and platinum plans that can be offered and for certain individuals under age 30 – a catastrophic plan can be offered. Contributions to a Health Savings Account (HSA) may be taken into account in determining the level of coverage offered by an employer. (Sec. 1302, pages 102-116)</p>	<p>The ADA supports no cost sharing for preventive services and ensuring oral health expertise on the advisory committee.</p> <p>This provision is consistent with Res. 60H passed by the ADA’s 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that will increase opportunities for individuals to obtain health insurance coverage in all U.S. jurisdictions.</p> <p>In an attempt to develop data that might help the ADA lobby for <b>adult dental Medicaid coverage</b>, the Association has proposed the following additional language be included in section 222 study: “Not later than 1 year after the date of enactment of this Act, the Secretary shall also submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults in the Medicaid program at a level necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.”</p>

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<p><b>Individual Mandate and Tax Credits</b></p>	<p>Individuals are required to have health insurance or pay a fee equal to 2.5 percent of their adjusted gross income or the average premium on the Exchange (whichever is lower). Exceptions are granted for financial hardship, dependents and religious objections. Individuals below the income tax filing threshold are exempt. (Sec. 501; pages 296-308)</p> <p>Tax credits are provided to those with family income below 400% of the federal poverty level (about \$43,000 for the individual and \$88,000 for a family of four) and the credit will be set on a sliding scale so that the premium contributions are limited to a certain percentage of the individual’s income. These credits are available only to those whose employers do not offer coverage or whose share of employer-sponsored coverage costs more than 12 percent of their family income. (Sec. 341-347; pages 225-267)</p>	<p>Beginning in 2014, requires individual to maintain minimum essential coverage or be subject to a penalty of \$95 in 2014, \$350 in 2015, \$750 in 2016 and indexed thereafter. Exceptions are granted for religious objectors, those who cannot afford coverage and others. (Sec. 1501, pages 320-340)</p> <p>Tax credits are provided to those with families with taxable income between 100-400 percent of the FPL, calculated on a sliding scale. Credits are available only to those employees whose employers do not offer coverage; however, an employee may enroll in the Exchange and receive credits where the employer provides less than 60 of the cost of the premium or the premium exceeds 9.8 percent of the employee’s income. (Sec. 1401, pages 238-259 )</p>	<p>The tax credit provision is consistent with ADA policy (Res. 60H) passed by the ADA’s 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that provides incentives for individuals to obtain health insurance coverage.</p>
<p><b>Employer Responsibility (Small Business Exception)</b></p>	<p>Employers are required to “play or pay” by either: (1) offering coverage and contributing not less than 72.5% of the lowest cost QHBP (65% for family coverage), or (2) paying a fee of 8% of payroll into a fund. A study will be conducted to examine the impact of this provision and whether a hardship exemption is warranted. (Sec. 411-416; pages 268-280)</p> <p><i>Small business exemption –</i></p>	<p>Employers who do <i>not</i> offer coverage and have more than 50 full-time employees must make a payment of \$750 per full-time employee if the employer has at least one employee receiving the premium assistance tax credit. Employers who do offer coverage and have more than 50 full-time employees but has at least one full-time employee receiving the premium tax credit will pay the lesser of \$3,000 for each of the employees</p>	<p>The Senate bill with a small business exemption for</p>

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	<p>Small businesses (less than \$500,000 annual payroll) will not have to contribute to their employees’ coverage and provides a graduated penalty for firms with payrolls between \$500,000 and \$750,000. (Sec. 512; pages 312-317)</p>	<p>receiving a credit or \$750 for each full-time employee. Employers with more than 200 employees are required to automatically enroll new full-time employees, although the employee has a right to opt out. (Sec. 1511-1515, pages 346-364)</p>	<p>employers of 50 employees or fewer comes closest to meeting the intent of ADA policy (Res. 60H) passed by the ADA’s 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that exempts small business employers from any mandate to provide health coverage.</p>
<p><b>Premium Subsidies to Small Businesses</b></p>	<p>Small businesses (fewer than 25 employees and average wages of less than \$40,000) will be eligible for a tax credit on a sliding scale. The full credit (50 percent of the premium cost) is available to employers with 10 or fewer employees and average wages of \$20,000 or less. (Sec. 521; pages 317-325)</p>	<p>Essentially the same as the House bill -- small businesses (fewer than 25 employees and average annual wages of less than \$40,000) will be eligible for a tax credit on a sliding scale. The full credit (50 percent of the premium cost) is available to employers with 10 or fewer employees and average wages of \$20,000 or less. (Sec. 1421, pages 307-320)</p>	<p>This provision is consistent with the intent of Res. 60H passed by the ADA’s 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that includes incentives for employers to provide health insurance coverage.</p> <p>The ADA strongly disagrees with phasing out the credit based on average employee compensation. That threshold is a blunt instrument that discriminates against small employers who must offer competitive wages in expensive markets, as well as businesses that employ a number of low income workers as well as higher earners and, on average, exceed the rather low limit in the bill. The ADA recommends eliminating the average wages threshold phase out amount.</p>
<p><b>Medicaid and CHIP</b></p>	<p>Medicaid is expanded to all individuals with incomes up to 150 percent of the federal poverty level (\$33,100 per year for a family of four); however, this does NOT include a <i>requirement</i> for dental services for adults. Adult dental remains a state option even though this provision expands</p>	<p>Medicaid is expanded to all individuals with incomes up to 133 percent of the FPL. There is no requirement for comprehensive adult dental services, although the benchmark coverage that must be provided to adults</p>	<p>Concerning <b>Medicaid</b>, none of the current health care reform proposals provide any additional funding for dental Medicaid programs.</p> <ul style="list-style-type: none"> <li>• We think it would be a tragic mistake if Congress passed health care reform but did</li> </ul>

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	<p>Medicaid coverage to children and adults up to 150 percent of the FPL. (Sec. 1701; pages 1012-1021)</p> <p>“Maintenance of effort” (MOE) provision requires states to continue coverage for those populations enrolled as of June 16, 2009 and includes childless adults. However, the ADA understands that this MOE provision is being interpreted as applying to eligibility only and does not obligate a state to continue benefits not required by federal law (such as the EPSDT program). As such, adult dental coverage remains a state option. (Sec. 1703; pages 1027-1034)</p> <p>Medicaid payment rates for primary care practitioners (does NOT include dentists) for providing primary care services will be paid at 80% of the Medicare rate for 2010, 90% for 2011 and 100% of the Medicare rate in 2012 and in subsequent years. (Sec. 1721; pages 1055-1058)</p> <p>CHIP-eligible children will be required to obtain coverage through the Exchange or Medicaid in 2014.</p> <p>No later than January 1, 2011, the Secretary will be required to develop a set of Medicaid quality measures for maternity care and adult health services. (Sec. 1730; pages 1069-1075)</p> <p>A state will not be considered to have met its</p>	<p>might offer some dental services. For example, the benchmark plans include the standard BC/BS preferred provider option plan in the FEHBP, the health benefits coverage plan that is offered and generally available to state employees, a health maintenance organization with the largest insured commercial, non-Medicaid enrollment of covered lives in the state involved. (Sec. 2001, pages 396-418)</p> <p>There is enhanced federal funding for the CHIP program. (Sec. 2101, pages 436-441)</p>	<p>nothing to improve the plight of those millions of low-income Americans who qualify for dental care under Medicaid but who can't access care due to severe underfunding of the program.</p> <ul style="list-style-type: none"> <li>• H. R. 3962 increases reimbursement for primary care physicians in Medicaid, but that provision does not include dentists. Since dentists are primary care providers, we should be included in that provision.</li> <li>• Another solution would be to include the Essential Oral Health Care Act (H.R. 2220) in health care reform. That measure provides states with enhanced federal matching funds if they choose to redesign their plans to pay dentists market rates, eliminate administrative barriers, educate caregivers and sign up enough dentists to provide care.</li> </ul> <p>The ADA is aggressively seeking an amendment to accomplish the above goal. In addition, the ADA is also seeking to ensure comprehensive dental services are available to the adult Medicaid population. This supports an emphasis on family-centered oral health care, empowering parents to serve as role models for their children.</p> <p>Regarding section 1728 in the House bill -- Recognizing that it takes more than just addressing payment rates to fix a Medicaid program, the ADA is lobbying for a proposal that would require the states to also report on actions taken to address</p>

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	<p>obligation under the Medicaid statute (including a requirement to pay providers at a rate sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area) unless the state annually submits to the Secretary a plan providing specific payment rates and data that allows evaluation of the state’s compliance. If rejected by the Secretary, the state is required to immediately submit a revised plan. (Sec. 1728; pages 1066-1067)</p> <p>Each year, states must submit a report to the Centers for Medicare and Medicaid Services (CMS) containing information on the determination of Medicaid rates paid to providers. There must be an explanation of the payment methodology and justification for the rates, as well as an explanation of the process that allows providers an opportunity to review and comment before the state made the rates final. (Sec. 1746; pages 1114-1115)</p> <p>There is also a requirement for a General Accountability Office (GAO) study regarding federal payments made to Medicaid programs. (Sec. 1747; pages 1115-1117)</p>		<p>administrative barriers. Specifically, the ADA proposal requests the addition of the following language: “A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) for a year unless the State also addresses administrative barriers that make it difficult for beneficiaries to access care and for providers to participate in the Medicaid program, including improving eligibility verification, ensuring that any licensed practitioner may participate in a publicly funded plan without also having to participate in any other plan, simplifying claims forms processing, assigning a single plan administrator for the dental program, employing case managers to reduce the number of missed appointments, and educating caregivers (such as parents and guardians) regarding the need to seek services.”</p> <p>Concerning the provisions in the House bill that require states to submit reports to the Secretary and CMS -- these reports could give constituent dental societies and the ADA a platform to highlight shortcomings in the dental Medicaid program with policymakers.</p> <p>Concerning CHIP in the House bill, it is important that the special needs of this population are properly met when transitioning to other plans.</p>

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<p><b>Health Care Quality Issues</b></p>	<p>There is established a Center for Quality Improvement headed by the Director of the Agency for Healthcare Research and Quality (AHRQ) who shall oversee the Center that develops clinical, managerial and health care delivery “best practices”. The AHRQ shall enter into agreements with “qualified entities” to develop quality measures. A “qualified entity” includes a nonprofit institution with technical expertise in the area of health quality measurement. (Sec 2401- 2403; pages 1322-1338)</p> <p>Within the AHRQ, a Center for Comparative Effectiveness Research (Center) will be established to conduct, support, and synthesize research with respect to outcomes, effectiveness and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated and managed clinically. The new Center for Comparative Effectiveness Research and the new Health Choices Commission are required to consult with the specialty colleges and academies of medicine in determining any official recommendation or standards for best practices. (Sec.1401; pages 733-761)</p> <p>The Center for Medicare and Medicaid Innovation (CMI) will be created within the Centers for</p>	<p>The Secretary shall establish a strategy to improve the delivery of health care services, patient health outcomes and population health and collaborate with state agencies in the development of the national strategy. The President shall convene the Interagency Working Group on Health Care Quality to coordinate actions among federal agencies and to avoid duplication of efforts. The Secretary, in consultation with AHRQ and CMS, shall identify gaps in quality measures for health plans and providers. Grants are authorized to carry out these activities. Multi-stakeholder groups will also be formed. Better data collection and analysis will be required and performance data on quality measures tailored to the needs of clinicians, consumers, policymakers, researchers and others will be available on the internet. (Sec. 3011-3014, pages 692-722)</p> <p>Similar to H.R. 3962, health care delivery research will be conducted by AHRQ (Sec. 3501, pages 1053-1062) and comparative clinical effectiveness research that evaluates health outcomes will be enhanced. (Sec. 6301, pages 1648-1689)</p> <p>A similar CMI provision is in the Senate bill. (Sec. 3021, pages 723-739)</p>	<p>The ADA recognizes the importance of developing quality measures that are understandable and acceptable to all stakeholders. As such, the ADA is moving quickly to establish the Dental Quality Alliance and believes the DQA should be the entity looked to for oral health quality measures.</p> <p>The ADA certainly supports research to improve the delivery of health care. However, it must also be recognized that the dental quality measurement activities are in their infancy stage and there is certainly no mechanism that could accurately identify individual providers that deliver high-quality care.</p> <p>The ADA will monitor these provisions and cautions against an expansion of the use of quality measures into the private insurance market in a manner that could mean that insurers are empowered to either develop or choose quality measures and tie those to reimbursement; perhaps disregarding efforts at developing quality measures through broad-based initiatives such as the newly established <b>Dental Quality Alliance</b>, in which the ADA participates.</p>

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	<p>Medicare and Medicaid Services (CMS). The CMI will test innovative payment and service delivery models to improve the coordination, quality and efficiency of health care services provided to Medicare and Medicaid recipients with the goal of reducing costs and increasing quality. (Sec. 1907; pages 1198-1207)</p>		
<p><b>Public Health Infrastructure</b></p>	<p>The Secretary, acting through the Centers for Disease Control and Prevention, shall establish a core public health infrastructure program that awards grants to state, local and tribal departments for the purpose of addressing infrastructure needs. A Public Health Investment Fund is established to provide additional appropriations for Federally Qualified Health Centers (FQHCs), National Health Service Corps (NHSC) loan repayments, the promotion of primary care medicine and dentistry in “health professional needs areas”, and a scholarship program and a lone repayment program run by the Health Resources and Services Administration called the “Frontline Health Providers Loan Repayment Program” to promote primary care and dentistry. (Sec. 2002; pages 1214-1219; Sec. 2211-2214; pages 1224-1240)</p> <p>The NHSC loan repayment program is strengthened by expressly permitting practitioners to participate on a half-time basis (offering an opportunity to also establish a private practice) and by increasing the annual full-time loan repayment amount to \$50,000 (from \$35,000). (Sec. 2201;</p>	<p>Appropriations are authorized for fiscal years 2010-2014 for <b>oral health infrastructure</b> – the CDC will enter into cooperative agreements with the states, territories and tribes to establish oral health leadership and program guidance, data collection, a multi-dimensional delivery system and to implement science-based programs (e.g. sealants and community water fluoridation). Sec. 4102, pages 1167-1173)</p> <p>The Secretary, through the CDC, shall provide funding for research in the area of public health services and systems. This research will be coordinated with Community Preventive Services Task Force and will examine practices relating to prevention with a focus on the priority areas identified in the National Prevention Strategy or Healthy People 2020 report. (Sec. 4301, pages 1240- 1241)</p> <p>The public health surveillance systems are strengthened (Sec. 2821, pages 1255-1257)</p>	<p>Adequate funding of the public health infrastructure, which fosters public-private collaboration, is necessary to help break the cycle of oral disease in our country. The ADA supports the establishment of a core public health infrastructure program within the Centers for Disease Control and Prevention and the Public Health Investment fund, which will provide additional appropriations for a number of public health programs.</p> <p>Regarding H.R. 3962 reauthorization of Title VII, the ADA is pleased the legislation established new funding opportunities and a separate section for the dental program. The Title VII sections also for the first time support teaching programs that address the oral health needs of vulnerable populations.</p> <p>In general, the ADA supports the infrastructure provisions in H.R. 3962 and is very pleased to see the improvements in the NHSC loan repayment program and the granting of liability protection to volunteers at health centers.</p>

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	<p>pages 1220-1223)</p> <p>The Secretary may also establish a NHSC demonstration program – offering <i>incentive payments</i> (in addition to salary and benefits otherwise owed) to any NHSC member who is assigned to a health professional shortage area with “extreme need.” Extreme need is defined as a health professional shortage area with high rates of untreated disease (including chronic conditions) where efforts to secure practitioners have proven unsuccessful with a priority given to primary care. (Sec. 2596)</p> <p>Volunteers at health centers are extended liability protection. (Sec. 2586; pages 1606-1608)</p> <p>The bill amends Title VII and reauthorizes training funds for the general practice, pediatric and public health dental residency programs. It established a separate section for the dental programs apart from primary and public health medicine programs. Dental hygiene training programs were also included in the new dental cluster. Funding is authorized for planning, developing and operating such programs, and financial assistance for students and faculty. The section also for the first time supports teaching programs that address the oral health needs of vulnerable populations. (Sec. 2215-2216; pages 1240-1246)</p>	<p>There is an enhancement of student loan funds for nursing and the medical pediatric workforce (not dental). (Sec. 5201-5203, pages 1316-1323) The Public Health Workforce Loan Repayment Program is established to increase loan repayments for public health professionals. (Sec. 5204, pages 1324-1328) The Allied Health Workforce Recruitment and Retention Program would be amended to provide grants to help eliminate shortages of allied health workers, including <b>dental hygienists</b>. (Sec. 5205, pages 1329-1332)</p> <p>Title VII is amended with a provision that provides support and development of dental training programs. There are grants to plan, develop and operate in training programs in the field of general, pediatric, or public health dentistry for dental students, residents, practicing dentists, <b>dental hygienists, or other approved primary care dental trainees</b>, which emphasizes training for general, pediatric or public health dentistry. The grants would also provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in such programs and who plan to work in the practice of general, pediatric, public health dentistry or dental</p>	<p>The ADA is seeking clarification of aspects of the Title VII language in the Senate bill that provides grants to approved primary care dental trainees.</p>

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	<p>The Secretary shall establish a <b>school-based health clinic</b> program. Preferences for funding will be given to schools with high percentage of medically underserved children. Before a clinic is established there must be evidence of local need and assurances that services will be provided in accordance with state and local laws and that the clinic has a collaborative relationship with other providers in the area. (Sec. 2511; pages 1352-1360)</p>	<p>hygiene. The grants would also help train those who would teach and provide loan repayment programs for dental faculty. (Sec. 5303, pages 1349-1355)</p> <p>Grants will be available to establish <b>school-based health center facilities</b> that provide comprehensive primary care, including oral health services. The purpose of the centers is to serve schools with a large population of Medicaid and CHIP-eligible children. The clinic must make every reasonable effort to establish and maintain collaborative relationships with health care providers in the catchment area. (Sec. 4101, pages 1156-1167 )</p> <p>Funding for National Health Service Corps loan repayments is increased. (Sec. 5207, page 1333) More funding is provided for FQHCs and the Secretary is required to use negotiated rule making to develop a comprehensive methodology and criteria for determining medically underserved populations and health professional shortage areas. (Sec. 5601-5602, pages 1508 - 1514)</p>	
<p><b>Wellness and Prevention</b></p>	<p>The Secretary shall develop a national strategy (and reports to Congress) designed to improve the nation’s health through evidence-based clinical</p>	<p>The bill establishes a National Prevention, Health Promotion and Public Health Council to coordinate a national prevention program,</p>	<p>This provision is consistent with Res. 60H passed by the ADA’s 2009 House of Delegates that states the ADA shall advocate for any health care reform</p>

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	<p>and community-based prevention and wellness activities. (Sec. 3121; pages 1289-1291)</p> <p>There is a Task Force on Clinical Prevention Services and a Task Force on Community Preventive Services that will work cooperatively, as well as infrastructure grants for states, local and tribal health departments. (Sec. 3131-1343; pages 1291-1308)</p> <p>A Prevention and Wellness Trust fund is established with initial funding of \$2.4 billion for fiscal year 2011 and increasing to \$3.6 billion by FY 2014, which will allocate grants to help fund research, community-based services, and public health infrastructure. (Sec. 3111; pages 1286-1289)</p> <p>The Secretary, through CDC, will award grants to support community health workers to educate and provide outreach in underserved communities – including addressing behavioral risk factors associated with untreated <b>dental and oral health</b> problems. (Sec. 2530; pages 1422-1430)</p>	<p>as well as a Preventive Services Task Force to review scientific evidence regarding the effectiveness of various services and to make recommendations. The task force will also coordinate with the Community Preventive Services Task Force run by the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices. There will also be an education and outreach campaign on the benefits of prevention and a fund to provide grants. (Sec. 4001-4004 , pages 1134- 1155)</p> <p>The CDC, in consultation with professional oral health organizations, shall establish a 5-year national, public education campaign focused on <b>oral healthcare prevention</b> and education. The science-based strategies would include community water fluoridation and school-based dental sealants, and grants to demonstrate the effectiveness of research-based dental caries management. (Sec. 4102, pages 1167-1170 )</p> <p>There is an initiative to expand the utilization of evidence-based prevention and health promotion in the workplace by tasking CDC with facilitating the establishment of employer-based wellness programs. (Sec. 4303, pages 1252-1255)</p>	<p>proposal that develops prevention strategies that encourage individuals to accept responsibility for maintaining their health and which may reduce costs.</p> <p>The ADA is pleased more emphasis is being put on prevention, which has always been a key component of oral health care in the United States. The ADA supports the establishment of a Prevention and Wellness Trust Fund in the House bill and the oral health prevention provisions in the Senate bill.</p> <p>Dentistry must be represented in preventive services task force. Rather than the ambiguous statement that the task force will be composed of “individuals with appropriate expertise” this provision should expressly require individuals be appointed to the task force with expertise in medicine, dentistry, mental health and other providers of primary preventive or pediatric services.</p> <p>The ADA supports the oral health prevention education provisions in H.R. 3962. The Association’s proposal for a new dental team member, the <b>Community Dental Health Coordinator</b> (CDHC), meets the needs identified in these provisions for a health care professional with the ability to work in the community providing necessary outreach and education.</p>

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<p><b>Workforce Issues</b></p>	<p>The Secretary shall establish a Public Health Workforce Corps and a Public Health Workforce Scholarship Program for graduate school programs in public health, dental public health programs and others. (Sec. 2231-2235;; pages 1253-1267)</p> <p>There are also Health Resources and Services Administration grant programs. One program provides grants (fellowships, etc.) for schools and other entities engaged in increasing the number of individuals in the field of public health workforce, including dental. Another program applies to medical residents. There is also funding for coordination of cultural competency and diversity programs, innovations in interdisciplinary care training. (Sec. 2241-2252; pages 1268-1275)</p> <p>The Secretary shall establish the Advisory Committee on Health Workforce Evaluation and Assessment to make recommendations to the Secretary and Congress on the adequacy of the nation’s health workforce. The Advisory Committee shall collaborate with a number of named advisory groups (including health professions organizations) and federal agencies. (Sec. 2261-2281; pages 1275-1286)</p>	<p>A National Health Care Workforce Commission is established to make recommendations regarding workforce, such as determining if the demand for health care workers is being met (including supply and distribution), evaluating training and education activities, revising national loan repayment programs, etc. One of the commission’s high priorities is the education and training capacity, projected demands, and integration with the health care delivery system of the <b>oral health care workforce capacity at all levels</b>. There is also a grant program to enable states to complete similar strategies. Finally, a National Center for Health Care Workforce Analysis is established to work with professional and educational organizations and state and regional centers for health workforce analysis for the purpose of data collection, analysis and reporting. (Sec. 5101-5103, pages 1278- 1316 )</p> <p>An <b>Alternative Dental Health Care Providers Demonstration Project</b> is established whereby the Secretary is authorized to award grants to 15 entities to establish demonstration programs to train “alternative dental health providers,” including community dental health coordinators (CDHC), advance practice dental hygienists, independent dental</p>	<p>The ADA supports increasing the number of dentists in the public health services.</p> <p>The <b>Alternative Dental Health Care Providers Demonstration Project</b> should be deleted, which would reduce the cost of the bill by about \$60 million over 10 years. Individual states are already assessing and addressing their unique dental access situations and producing a wide variance of solutions. States have successfully worked to develop these new models by finding their own funding sources.</p>

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		hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other professional the Secretary determines is appropriate. Entities eligible to receive grants include institutions of higher education, community colleges, FQHCs, IHS facilities, a state or county public health clinic, a public-private partnership, or a public hospital or health system. The program must be accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution. Nothing shall prohibit a dental health aide training program approved by the IHS from being eligible for a grant. (Sec. 5304, pages 1355-1358 )	
<b>Health Information Technology; Electronic Health Records</b>	<p>Within two years of enactment of the legislation, the Secretary will be required to adopt comprehensive standards to allow implementation of financial and administrative transactions, including near real-time adjudication of claims, electronic funds transfers, machine-readable health plan beneficiary identification cards, etc. (Sec. 115; pages 76-89)</p> <p>The Secretary shall conduct a study of potential methods to increase the use of electronic health records by small health care providers. The study shall consider at least one of the following methods – providing higher reimbursement or</p>	Not later than 180 days after enactment, the Secretary shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs, which also apply to group health plans and health insurance issuers. (Sec. 3021, pages 373-396)	ADA policy (Res. 60H) passed by the 2009 House of Delegates states the Association shall advocate for any health care reform proposal that encourage the use of electronic health records with rigorous privacy standards.

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	other incentives; promoting low-cost electronic health record software packages; training and education; and providing assistance regarding implementation. (Sec. 263; pages 153-154)		
<b>Medical Liability Alternatives (Tort Reform)</b>	The Secretary shall make incentive payments to states with new alternative medical liability laws (only laws enacted after enactment of health care reform qualify). The new law must make the liability system more reliable through prevention or by promoting prompt resolution of disputes. There must also be disclosure of health care errors and maintenance of access to affordable liability insurance. The litigation alternatives consisting of certificate of merit and early offer are acceptable; but there can be no limit on attorneys’ fees or caps on damages. (Sec. 2531; pages 1431-1433)	The bill includes a “sense of the Senate” provision that states should be encouraged to develop and test alternatives to the existing litigation system (while preserving an individual’s right to seek redress in court) and Congress should consider establishing a state demonstration program. (Sec. 6801, pages 1858-1859)	The ADA does not support either provision. Neither the House nor Senate bills provide meaningful tort reform, which should include limits on non-economic damages and reasonable limits on attorneys’ fees. ADA policy, including Res. 60H passed by the ADA’s 2009 House of Delegates, requires the ADA to support medical liability (tort) reform. The ADA supports tort reform legislation that includes but is not limited to mandatory periodic payments of substantial awards for damages; a ceiling on non-economic damages; mandatory offsets of awards for collateral sources of recovery; limits on attorneys’ contingency fees; a statute of limitations on health care-related injuries; and state duties concerning alternative methods of resolving disputes.
<b>Health Savings Accounts, Health Flexible Spending Arrangements</b>	Amounts paid for medicine or drugs will be deductible as a medical expense only if it is prescribed or is insulin. Salary reduction contributions to health flexible spending arrangements through a cafeteria plan will be limited to \$2,500 (indexed for inflation). Currently there is no statutory limit on the amount an employee can contribute. The penalty for nonqualified distributions from health savings	There would be a \$2,500 annual limit on the amount of salary reduction contributions to flexible spending arrangements (FSAs). (Sec. 9005, page 1999) The penalty for nonqualified distributions from health savings accounts and Archer MSAs (such as distributions that are not used to pay for health care expenses) will be increased from 10 percent to 20 percent. (Sec. 9004, page	The ADA believes the \$2,500 cap on FSAs should be removed. Res. 60H passed by the ADA’s 2009 House of Delegates requires the ADA to support HSAs and FSAs. The ADA has long supported (both in coalitions and independently) the expanded use of health savings accounts and health flexible spending arrangements as an effective means of promoting access to dental services in a manner that maximizes consumer choice of provider. The

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	accounts (such as distributions that are not used to pay for health care expenses) will be increased from 10 percent to 20 percent. (Sec. 531-533; pages 324-327)	1998) Over-the-counter medicine would no longer be eligible for reimbursement under HSAs, FSAs, or HRAs. (Sec. 9003, page1997-1998)	Association will continue to fight the cap on flexible spending arrangements.
<b>Dental Emergency Responders</b>	The legislation amends the Homeland Security Act to expressly include dentistry as part of the national preparedness system along with colleagues in medicine and public health. (Sec. 2555-2556; pages 1489-1490)	Not addressed in the Senate bill, as introduced.	This provision is consistent with ADA policy calling for the Association to advance the role of dentistry in disaster planning and emergency preparedness. It mirrors the “Dental Emergency Responder Act”, H.R. 903, which the ADA helped develop and has actively lobbied, both individually and in a coalition.
<b>Practitioner Data Banks</b>	The bill eliminates duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB) by sun setting the HIPDB after assuring the information collected by the HIPDB is picked up by the NPDB. (Sec. 1652; pages 1006-1010)	The Senate bill also eliminates duplication between the HIPDB and the NPDB. (Sec. 6403, pages 1747-1760)	
<b>Indian Health Care Improvement Act</b>	The bill incorporates many provisions of the IHCIA, including the ADA-agreed language that limits the scope of practice for a Dental Health Aide Therapist (DHAT) in Alaska (see pages 1713-1714) and that precludes DHATs from being part of the Community Health Aide Program beyond Alaska (see page 1716). (IHCIA : pages	Not addressed in the Senate bill, as introduced.	ADA supports the provisions noted in the summary of H.R. 3962.

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	1635-1990)		
<p><b>Mandatory Coverage for Children with Congenital or Developmental Deformity, Disease, or Injury</b></p>	<p>Beginning January 1, 2010, group health plans (both in and outside the Exchange) must provide outpatient and inpatient diagnosis and treatment coverage for a minor child’s (21 years of age or younger) congenital or developmental deformity, disease, or injury. (Sec. 108; pages 42-45)</p>	<p>Not addressed in the Senate bill, as introduced.</p>	<p>The ADA supports coverage for the diagnosis and treatment of congenital or developmental deformity, disease, or injury because ensuring coverage for cleft lip and palate has been difficult.</p>
<p><b>Standards for Accessible Medical Diagnostic Equipment</b></p>		<p>Not later than 24 months after passage of this Act, the Architectural and Transportation Barriers Compliance Board, in consultation with the FDA, shall promulgate standards setting forth the technical criteria for medical diagnostic equipment, <b>including equipment used for dental examinations or procedures</b>. The standards shall ensure the equipment is accessible to, and usable by, individuals with accessibility needs and shall allow independent entry to, and use of, the equipment by the individuals to the maximum extent possible. (Sec. 4203, pages 1220-1221)</p>	<p>If this provision becomes law, the ADA will work to ensure there is a proper balance between cost of implementation, which might affect access to care, and the needs of individuals with special needs.</p>

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<p><b>Paying for Health Care Reform</b></p>	<p>There are a variety of relatively small provisions but the primary revenue raiser is a surcharge on adjusted gross income above \$1 million (married filing jointly) and \$500,000 (single), which is estimated to raise over \$460 billion over 10 years. (Sec. 551; pages 336-339)</p> <p>The changes in HSAs and FSAs mentioned above are estimated to raise just under \$20 billion over 10 years.</p> <p>There is also an excise tax on the first taxable sale of medical devices (any device intended for humans) equal to 2.5 percent of the price. “First taxable sale” means the first sale for a purpose other than resale after the device has been produced or imported. If a medical device is sold for use in connection with providing any health care service to an individual, such sale shall not be treated as being for the purpose of resale. (Sec. 552; pages 339-344)</p>	<p>The bill places a 40 percent tax levied on insurance companies or plan administrators for any plan above \$8,500 for single coverage and \$23,000 for family coverage. The tax would apply to the portion of the premium in excess of the threshold. All group health policies (e.g. dental, vision, FSAs, HSAs) offered to the same employee would count toward the threshold. (Sec. 9001, pages 1979-1996)</p> <p>There would be a \$2,500 annual limit on the amount of salary reduction contributions to flexible spending arrangements (FSAs). (Sec. 9005, page 1999)</p> <p>An annual flat fee of \$2 billion will be imposed on the companies that manufacture or import medical devices beginning in 2010, apportioned among the manufacturing sector based on market share. (Sec. 9009, pages 2020-2026)</p> <p>The bill imposes a 5% excise tax on voluntary “cosmetic surgery and medical procedures.” The tax would be imposed on the patient and collected from the health care professional at the point of service. “Cosmetic surgery and medical procedures” is defined as any “cosmetic surgery” as defined under section 213(d) (9) (B) of the Internal Revenue Code. That provision</p>	<p>The ADA opposes the \$2,500 cap on FSAs and the excise tax placed on medical devices. The ADA opposes limits and/or restrictions on Flexible Spending Accounts because they serve as a valuable means of using pre-tax dollars to pay for health care services without the bureaucratic hassles generally associated with health benefit plans. A tax on medical devices would add an unnecessary additional expense to the delivery of health care.</p> <p>ADA policy (Res. 60H) passed by the ADA’s 2009 House of Delegates states the ADA shall support a health care reform proposal that is funded in a sustainable, budget neutral manner that does not include a tax on health care delivery.</p> <p>The ADA opposes the various taxes on health care benefits or health care services in the Senate bill because of the chilling effect on expanding coverage and access to health care services.</p>

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		<p>defines “cosmetic surgery” as – “any procedure which is directed at improving the patient’s appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.” (Sec. 9017, pages 2045-2046)</p> <p>The penalty for nonqualified distributions from health savings accounts and Archer MSAs (such as distributions that are not used to pay for health care expenses) will be increased from 10 percent to 20 percent. (Sec. 9004, page 1998) Over-the-counter medicine would no longer be eligible for reimbursement under HSAs, FSAs, or HRAs. (Sec. 9003, page1997-1998)</p> <p>The bill would increase the hospital insurance tax (Medicare) by .5 percent for individuals earning over \$200,000 or over \$250,000 for those who file jointly. (Sec. 9015, pages 2040-2044)</p> <p>A new “Simple Cafeteria Plan” for small businesses is established, which will enable such businesses to be better able to offer tax-free benefits to their employees. (Sec. 9022, pages 2050-2057)</p>	

*Please note:* This side-by-side reflects all relevant changes made to H.R. 3962 as it was passed by the House of Representatives on November 7. The page numbers for each section (which still refer to the October 29<sup>th</sup> version of H.R. 3962) have not been adjusted.