

Health Care Reform Legislation: Implementation Timelines April 2010

“Patient Protection and Affordable Care Act”

P.L. 111-148

(H.R. 3590)

And

“Health Care and Education Affordability Reconciliation

Act of 2010”

P.L. 111-152

(H.R. 4872)

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Oral Healthcare Prevention

- The CDC will enter into cooperative agreements with the states, territories and tribes to establish oral health leadership, program guidance and data collection, and to implement science-based programs, such as sealants and community water fluoridation.
- The CDC, in consultation with professional oral health organizations, shall establish a **5-year national, public education campaign focused on oral healthcare prevention 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.

Oral Healthcare Workforce

- Title VII is amended to create a “dental cluster” 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, dental hygienists, or other approved primary care dental trainees, 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 hygiene. The grants would also help train those who would teach and provide **loan repayment programs for dental faculty**.
- For fiscal years 2011-2014, funding is authorized for grants to provide **geriatric education training centers** to support training that focuses on geriatrics, chronic care management and long-term care for faculty in health professions, including **schools of dentistry** and public health. Funding is also established to support training for family caregivers; to develop best practices in geriatrics and to expand geriatric career awards to health professionals, including **dentists**.
- An **Alternative Dental Health Care Providers Demonstration Project** 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 hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other professional the Secretary determines is appropriate. The program must be accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution. **Each entity receiving a grant under this section shall certify it is in compliance with all applicable state licensing requirements. Nothing shall prohibit a dental health aide training program approved by the IHS from being eligible for a grant.**

Indian Health Care Improvement Act

- The bill, by reference, includes the IHCA as reported by the Senate Committee on Indian Affairs in December 2009 (S. 1790). The bill also contains a number of key amendments to the IHCA. The new law includes the ADA-agreed language that limits the scope of practice of a Dental Health Aide Therapist (DHAT) and contains the general prohibition that precludes DHATs from being part of the Community Health Aide Program (CHAP) beyond Alaska if the program is nationalized by the Secretary.
- However, there is an exception to the general prohibition of DHATs practicing outside of Alaska under the CHAP program. Specifically, **DHATs will be permitted in the CHAP program if requested by an Indian tribe or tribal organization located in a state in which the use of DHAT or midlevel provider**

services is authorized under state law to supply such services in accordance with the state law.

- There is also a general statement that **nothing shall restrict the ability of the Service, an Indian tribe, or tribal organization from participating in any program or to provide any service authorized by any other federal law.**
- The bill also states the Secretary shall not fill any vacancy for a dentist with a DHAT.
- Finally, an Interagency Access to Health Care in Alaska Task Force is established. The task force will be composed of representatives of the federal government with a goal of making recommendations to Congress concerning improving access to health care.

Healthcare Workforce (including oral health)

- 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. Appointments will be made by September 30, 2010.
- 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 **oral** health care workforce capacity at all levels. There is also a grant program to enable states to complete similar strategies.
- A National Center for Health Care Workforce Analysis is established to work with professional and educational organizations and state and regional centers.

Public Health Infrastructure

- Funding for National Health Service Corps loan repayments is increased.
- Payments under the National Health Service Corps loan repayment program and similar state loan repayment programs will not be subject to taxation.
- The Public Health Workforce Loan Repayment Program is established to increase loan repayments for public health professionals. The Allied Health Workforce Recruitment and Retention Program would be amended to provide grants to help eliminate shortages of **allied health workers, including dental hygienists.**
- The Secretary is authorized to award grants to teaching health centers for new primary care residency programs. The **ADA** is mentioned as an accrediting entity.
- Grants will be available to establish school-based health center facilities that provide comprehensive primary care, including **oral** health services in 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.
- Individuals who work at free clinics are extended medical liability protection.
- 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.
- The bill establishes a National Prevention, Health Promotion and Public Health Council to coordinate a national prevention program, 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.
- 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.
- 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.
- The public health surveillance systems are strengthened and the bill establishes a United States Public Health Sciences Track.

Medicaid/CHIP

- Expands the Medicaid and CHIP Payment and Access Commission (MACPAC) to include assessments of adult services, including services for dually-eligible individuals. The MACPAC will assess policies affecting Medicaid beneficiaries, including **payments to providers.**
- The Secretary shall conduct a study to examine the feasibility of adjusting the application of the Federal Poverty Level (FPL) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States.

Health Care Quality

- The President will convene the Interagency Working Group on Health Care Quality to coordinate actions among federal agencies.

- 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 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.

Medical Malpractice Reform

- Beginning in fiscal year 2011, the Secretary is authorized to award grants to states for the development of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. Reports shall be sent to Congress annually and the Secretary shall contract with an appropriate research organization to evaluate the program.

Revenue

- After July 1, 2010, the proposed tax on voluntary “cosmetic surgery and medical procedures” was eliminated in favor of a tax on indoor tanning services.
- 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.

Data Bank

- The Senate bill eliminates duplication between the HIPDB and the NPDB.

Fraud and Abuse

- Authorizes the Centers for Medicare & Medicaid Services (CMS) to work collaboratively with the Internal Revenue Service (IRS) to disclose to CMS those entities that have evaded filing taxes and matching the data against provider billing data to enable CMS to better detect fraudulent providers billing the Medicare program.
- Increases funding for the Health Care Fraud and Abuse Control Fund and indexes funds to fight Medicaid fraud based on the increase in the consumer price index.

Not Later than 90 days after Enactment

Insurance Reforms

- The Secretary will establish a temporary high risk health insurance pool program that will provide grants to states to provide immediate access to coverage for individuals with a pre-existing condition. This program will end on January 1, 2014.
- The Secretary shall also establish a temporary reinsurance program for early retirees, which provides a portion of the cost of coverage by participating employment-based plans.

Plan Years Beginning 6 Months after Enactment

Insurance Reforms

- Prohibits lifetime or annual limits for essential health benefits, prohibits rescissions, puts limitations on excessive waiting periods, prohibits pre-existing condition exclusions for *children*, and establishes a requirement to provide coverage for non-dependent children up to age 26.

Health Plan Administrative Simplification

- The Secretary will develop standards and protocols that facilitate enrollment of individuals in federal and state health programs, which also apply to group health plans and health insurance issuers.
- Regarding administrative simplification, the operating rules for health information transactions to facilitate the electronic exchange of information shall be adopted by the Secretary in order to facilitate determination of an individual's coverage eligibility and financial responsibility, the establishment of transparent claims and denials management processes, and a means to reduce the number and complexity of forms, among other objectives.

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Within 2 years after Enactment

Healthcare Quality

- To improve quality of care the Secretary shall develop reporting requirements regarding plan coverage and provider reimbursement structures that are designed to improve outcomes.
- The Secretary shall develop provider-level outcomes measures for hospitals, physicians and other providers as determined appropriate by the Secretary. The measures will include the five most prevalent and resource-intensive acute and chronic medical conditions, as well as primary and preventive care.
- Health care delivery research will be conducted by AHRQ and comparative clinical effectiveness research that evaluates health outcomes will be enhanced.
- A Center for Medicare and Medicaid Innovation (CMI) is established within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models.
- The Architectural and Transportation Barriers Compliance Board, in consultation with the FDA, shall promulgate standards setting forth the technical criteria for medical diagnostic equipment, including equipment used for dental examinations or procedures. 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.

Changes to Consumer-Directed Plans (e.g. HSAs)

- After December 31, 2010, excludes over-the-counter drugs not prescribed by a doctor from reimbursement from health reimbursement arrangements (HRA), flexible spending accounts (FSAs), health savings accounts (HSAs) or Archer medical savings accounts (MSAs).
- After December 31, 2010, 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.

Wellness

- Establishes the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention, wellness and public health activities. Strategy is due within one year of enactment.
- Establishes a Prevention and Public Health Fund for prevention, wellness and public health activities including prevention research and health screenings, the Education and Outreach Campaign for preventive benefits, and immunization programs.

Medicare

- Freezes the Medicare threshold for income-related Part B premiums for 2011-2019.
- Reduces the Medicare Part D subsidy for individuals with income over \$85,000 and couples over \$170,000 beginning in 2011.
- Eliminates cost-sharing for preventive services, provides beneficiaries access to a comprehensive health risk assessment and creation of a personalized prevention plan in 2011.

Insurance Reform

- Beginning in 2011, health insurance issuers will have to maintain a medical loss ratio (the fraction of revenue from a plan's premiums that goes to pay for medical services) of at least 85 percent for the large group market and 80 percent for the individual and small group market in order to avoid paying rebates.

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Insurance Reform

- Not later than July 1, 2013, two or more states may enter into an agreement to permit the offering of qualified health plans in the individual market across state lines. Also, an insurance issuer may offer a nationwide qualified health plan for individuals or the small group market, except in states that opt-out.

Revenue

- Beginning in 2013, there would be a \$2,500 annual limit on the amount of salary reduction contributions to flexible spending arrangements (FSAs).
- An excise tax of 2.3% will be imposed on the companies that manufacture or import medical devices beginning in 2013, apportioned among the manufacturing sector based on market share.
- After December 31, 2012, the bill would increase the hospital insurance tax (Medicare) by .9 percent for individuals earning over \$200,000 or over \$250,000 for those who file jointly. There is also a new Medicare hospital insurance tax that includes net investment income, such as interest, dividends, rents, and royalties, for the same high-income individuals or joint filers.
- Increases the threshold for itemized deduction for unreimbursed medical expenses from 7.5% of adjusted

gross income to 10% beginning in 2013. The increase is waived for individuals 65 and over for tax years 2013-2016.

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State Exchanges

- Individuals and small employers (not more than 100 employees) will be able to purchase qualified health plans (QHPs) through a *state* run American Health Benefit Exchange 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. 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.
- 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.
- **Stand-alone dental plans** 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 qualified health plans (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.
- States may receive grants to provide consumer assistance and insurance ombudsman programs. The Secretary, in conjunction with the states, shall establish a process for annual reviews of unreasonable increases in insurance premiums.

Qualified Health Benefit Plans

- All Qualified Health Plans (QHPs) must provide an essential health benefits package as defined by the Secretary – but which shall include pediatric oral care, 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, such as those under age 30, a catastrophic plan can be offered.

Health Savings Accounts (HSAs)

- Contributions to a Health Savings Account (HSA) may be taken into account in determining the level of coverage offered by an employer.
- It appears that HSAs and HSA “compatible products” (the high deductible medical plan that is purchased along with the HSA) will continue to effectively operate within the exchanges because most such plans meet the 60 percent actuarial value threshold required as a minimum for all essential benefit packages. After 2014, HSAs can be offered in exchanges (which will cover individuals and small employers) and in group health plans in the large employer market. Individuals (who do not purchase their coverage in an exchange) will be able to renew their HSAs after 2014.

Individual Mandate

- Beginning in 2014, requires individuals to maintain minimum essential coverage or be subject to a penalty of \$95 in 2014, \$325 in 2015, \$695 in 2016 or pay 2.5% of income, whichever is higher. Exceptions are granted for religious objectors, those who cannot afford coverage and others.
- 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.

Employer Mandate/Small Business Exception

- Businesses with 50 or fewer full-time employees are exempt from any responsibility to provide coverage.
- Employers who do *not* 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 \$2,000 for each of the employees receiving a credit or \$750 for each full-time employee but the first 30 employees are exempt from the assessment.
- Employers with more than 200 employees who offer coverage are required to automatically enroll new full-time employees and continue the enrollment of current employees, although the employee has a right to opt out.

	<p>Small Business Tax Credit and SHOP Exchange</p> <ul style="list-style-type: none"> • Small businesses (fewer than 25 employees and average annual wages of less than \$50,000) 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 \$40,000 or less (multiplied by a cost-of-living adjustment for years after 2013). • 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. <p>Insurance Reform</p> <ul style="list-style-type: none"> • For group health plans, prohibits pre-existing condition exclusions in 2014. • Effective 2014, additional market reforms include prohibition of pre-existing conditions as applied to <i>adult</i> coverage, fair health insurance premiums and comprehensive coverage, guarantee issue and renewability, prohibition of annual limits on coverage, premium rating limits, non-discrimination based on health status, non-discrimination of providers, and prohibition on excessive waiting periods. There is also a right of the individual to maintain existing coverage. <p>Medicaid/CHIP</p> <ul style="list-style-type: none"> • Beginning in 2014, 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 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. • Any clinical preventive services assigned a grade A or B by the United States Preventive Services Task Force will be included for Medicaid-eligible adults. • There is 100% federal support for all states for newly eligible individuals from 2014-2016, 95% support for 2017, 94% in 2018, 93% in 2019, and 90% support for 2020 and subsequent years. • There is enhanced federal funding for the CHIP program and Medicaid/CHIP enrollment simplification. • A state may award grants to providers who treat a high percentage (as determined by the state) of medically underserved populations or other special populations. <p>Revenue</p> <ul style="list-style-type: none"> • Beginning in 2014, an annual fee will be imposed on entities engaged in the business of providing health insurance, apportioned based on market share, with an exception for non-profits that target low-income populations.
<p style="font-size: 48pt; text-align: center;">2 0 1 8</p>	<p>Revenue</p> <ul style="list-style-type: none"> • The bill places a 40 percent tax levied on insurance companies or plan administrators for any plan above \$10,200 for single coverage and \$27,500 for family coverage in 2018, increased over time consistent with the cost-of-living adjustment. The tax would apply to the portion of the premium in excess of the threshold. There is a transition rule for states with highest premium costs. • The value of dental and vision plans would not be included in making the determination as to whether the plan exceeds the threshold.