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Re: Affordable Care Act repeal and priorities

Dear Representative,

On behalf of the American Dental Association (ADA) and our 161,000 member dentists, we appreciate the opportunity to share our priorities as Congress and the new administration considers replacement legislation for the Affordable Care Act (ACA). Our members have many roles in the health care system as health care professionals, small business owners and consumers.

The ADA believes that any effort to replace the existing law should not result in Americans losing dental coverage gained under the ACA, should emphasize value while supporting the doctor-patient relationship, ensure a competitive insurance marketplace, and safeguard the most vulnerable among us who rely on Medicaid for their health coverage.

In summary:

- Future changes to the current U.S. healthcare system should not result in Americans losing dental coverage gained under the ACA.

- Any changes made that affect the insurance market should foster competition while ensuring consumers can purchase high-quality, comprehensive oral health coverage that includes a separate dental deductible, first-dollar coverage for preventive services, and limits patient out-of-pocket costs.

- Any changes to Medicaid should preserve the existing requirement for oral health services for children up to age 21 and increase access to oral health services for low-income adults, vulnerable elders and low-income pregnant women.

- U.S. consumers deserve greater plan transparency so that they can be empowered to make personally-responsible decisions about their healthcare. Such transparency can be fostered through the use of quality metrics at the plan level that have been endorsed by the Dental Quality Alliance,[1] consumer satisfaction ratings, and easy-to-use and accurate participating provider lookup tools.

- The expansion of Title VII training programs for dentistry, additional funding authorization for the National Health Service Corps, and funding for community health centers (CHCs) should be preserved to ensure a strong public health infrastructure.

[1] The Dental Quality Alliance, convened by the ADA, seeks to advance performance measurement as a means to improve oral health, patient care and safety through a consensus-building process.

Competition

The ADA believes that any changes to the insurance marketplace should foster competition while establishing minimum standards for such competition. The ADA supports a benefit design that improves long-term health outcomes. Expanding consumer choice should not equate to offering minimal services at the lowest cost possible. Currently, there is no set of dental services that must be covered with appropriate cost-sharing for children and adults in the marketplace.[2] This has resulted in plan offerings that cover limited services and/or have high cost-sharing. We believe that the ADA, as America's leading advocate for oral health and with vast resources that promote evidence-based care, is well-positioned to define such a standard and collaborate with plans and other stakeholders to ensure greater competitive choices. Redesigning plan offerings presents an opportunity to emphasize value and improve health outcomes.

The ADA also believes that limiting cost exposure for preventive services will empower consumers with the opportunity to take additional responsibility for their own oral health. Benefit plan designs should allow for and incentivize consumer choice to purchase high-quality, comprehensive oral health coverage that includes separate dental deductibles, first-dollar coverage for preventive services and limits patient out-of-pocket costs. It is important to consider total costs rather than simply lowering overall premium costs. The combination of premiums and out-of-pocket costs impact affordability and influence patient behavior. The ADA believes that everyone should have the opportunity to achieve optimal oral health.

As Congress considers replacement legislation, the ADA supports federal tort reform legislation designed to rectify the problems in the current system which we believe unnecessarily contribute to the cost of health care. We support tort reform that includes but is not limited to 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 alternative methods of resolving disputes.

Additionally, the ADA supports a repeal of the McCarran-Ferguson antitrust provision that currently grants health insurance plans an exemption from certain antitrust laws. Any alternative replacement legislation should interject more competition into the marketplace by authorizing greater federal antitrust enforcement in instances where state regulators fail to act. Without robust competition, we believe consumers are more likely to face higher prices and less likely to benefit from innovation**.** We also believe that all benefit administrators should publicly report their market share (lives enrolled) by local markets**.**

Medicaid

Over 70 million Americans rely on Medicaid for their health care coverage today. This includes individuals who have gained access to Medicaid as a result of the ACA expansion. The ADA understands the need to increase state flexibility in order for Medicaid programs to adequately serve a diverse population and foster innovation, but we believe any changes to the program should not negatively impact access to oral health services. This includes preserving the existing requirement for oral health services for children up to age 21, as well as increasing access to oral health services for low-income adults, vulnerable elders, and low-income pregnant women.

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[2] The ACA utilizes the US Preventive Services Health Task Force and the Bright Futures guidelines to determine evidence-based standards for preventive care. Neither comprehensively address oral health services.

As states continue to shift their Medicaid programs to managed care, we believe states should ensure that beneficiaries have access to high quality care. This includes maintaining oral health network adequacy, providing oversight of outreach performed by plans or state programs to educate enrollees on plan options and the importance of oral health, requiring quality reporting by plans, and additional oversight by the Centers for Medicare and Medicaid Services (CMS) to guarantee that actuarially sound payment rates are in place to ensure quality care while controlling costs.

Transparency and Value

The ADA believes that all plan sponsors, including employers that offer self-funded plans, third-party payers and Medicaid plans, should be required to disclose information that is essential in helping consumers make informed decisions. This includes quality metrics at the plan level that have been endorsed by the DQA consumer satisfaction ratings, and easy-to-use and accurate participating provider lookup tools. In addition to premium and benefit plan summary data, this information is essential for well-informed consumer choice. Further, the ADA supports requiring the use of medical and dental loss ratios, ensuring that plans are providing a good value to consumers. Currently stand-alone dental plans are considered exempt from such disclosure.

The ADA believes that any replacement legislation should require streamlining efforts for quality reporting. While this has occurred to some extent in the broader healthcare arena through the Medicare Access and CHIP Reauthorization Act (MACRA) and the National Quality Forum, much remains to be done for dentistry. The ADA supports a requirement for CMS to engage in a public-private partnership with the DQA when implementing quality measures for dentistry.

The ADA also believes any replacement legislation should provide tax credits for both individuals and small businesses to help with the purchase of health insurance coverage, including dental plan coverage. We also believe that the use of tax preferred accounts, such as Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs), should be expanded. Prior to the ACA becoming law, individuals were able to set aside up to $5,000 annually to help with the cost of medical and dental care for themselves and their families. Restoring the pre-ACA limits will allow consumers to pay for necessary care that may not be covered under an existing medical or dental plan.

Public Health

The ACA contained a number of provisions supported by the ADA that directly impact our public health system and infrastructure. Such provisions include an expansion of Title VII training programs for dentistry, additional funding authorization for the National Health Service Corps, and funding for community health centers (CHCs). CHCs provide necessary care to vulnerable populations, including uninsured individuals and those enrolled in Medicaid. Many CHCs have dental clinics or work with dentists in their communities to ensure that necessary dental services are available to patients seeking care. We believe that Congressional support for CHCs should continue.

The ADA has also worked closely with the Centers for Disease Control and Prevention (CDC) for many years to ensure funding is appropriated for community oral health prevention programs. The CDC oversees important programs such as school-based sealant projects, community water fluoridation grants and efforts to increase oral health literacy. We strongly support maintaining the funding and authority for the CDC's Division of Oral Health.

We appreciate the opportunity to share our priorities and look forward to working with members of Congress and the incoming administration as replacement legislation is crafted. The ADA believes every individual should have access to oral health services and that a robust commercial marketplace, high-quality public health insurance programs and efforts to achieve cost-effective, quality care should be included in any new legislation.

Should you have additional questions please feel free to contact Ms. Janice E. Kupiec, kupiecj@ada.org or 202-789-5177 in our Washington, DC office.

Sincerely,

/s/

Gary Roberts, D.D.S.
President

/s/

Kathleen T. O'Loughlin, D.M.D., M.P.H.
Executive Director

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