Potential Effects of the Affordable Care Act on Dentistry
August 8, 2013

The “Patient Protection and Affordable Care Act” (ACA) was signed into law on March 23, 2010. And, on March 30, 2010, the ACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010. The ACA has the potential to reshape health care in America. The expansion of medical insurance coverage, a move toward more integrated care delivery, and significant changes to how health care is financed are some of the main changes expected. Obviously, given its length and complexity, the ACA affects the health care delivery system in a number of areas. The ADA’s primary focus has been on understanding the law’s potential effects on dentistry and the dental delivery system. This report provides an update on certain critical aspects of the ACA and their potential effect on dentistry.

Health Insurance Coverage Expansion

A primary goal of the ACA is to increase health insurance coverage through expanding Medicaid and establishing health benefit exchanges (marketplaces) that provide opportunities to purchase private sector coverage.

- Expanding Medicaid
  - The ACA provides for the expansion of Medicaid to cover adults with incomes up to 133 percent (138 percent, net of income disregards) of the federal poverty level (FPL). This population is generally referred to as the “newly eligible.”
  - The federal government is obligated to pick-up 100 percent of the cost of covering this additional population initially and 90 percent of the cost long term.
  - The actual expansion of Medicaid coverage will vary significantly depending on how states respond to the Supreme Court ruling last June, which held that the federal government could not withhold all federal Medicaid funds from states that refuse to expand their programs. To date, 23 states and the District of Columbia have indicated they will participate in the expansion.
  - There is no requirement to provide dental services to the newly eligible adults but states have the option to add those services if they choose to do so.
  - Millions of additional children and adults will have dental Medicaid benefits. The exact number will depend on how many states accept the ACA money and expand their Medicaid program.
• **Establishing exchanges** (essentially a web page that serves as a virtual marketplace in each state, D.C., and the territories) to help individuals and small businesses (up to 100 employees) buy private coverage.

  o Exchanges must be in place in time to begin enrolling beneficiaries by October 2013. They must be fully operational by January 1, 2014.
  
  o Initially, the exchange will be available only to individuals and small businesses, allowing the purchasers to select from various private health care plans.
  
  o People with incomes between 100-400 percent of the FPL are eligible to receive tax credits to subsidize their coverage through the exchange.
  
  o As of January 1, 2014, all plans participating in the exchange (and in the individual and small group markets outside the exchange) must meet ACA and state-established standards to become “qualified health plans” (QHPs), except stand-alone dental plans.
  
  o In general, all QHPs must offer an “essential health benefit” (EHB) package defined in the ACA as 10 categories of care, including pediatric dental coverage. The exception to this requirement is that a QHP in the exchange does not have to offer the pediatric dental EHB if there is a stand-alone dental plan in the exchange offering the benefit.
  
  o To ensure a consistent level of consumer protections, stand-alone dental plans must offer the pediatric dental EHB without annual and lifetime limits. Stand-alone dental plans will also likely have to meet certain marketing requirements, ensure a sufficient choice of providers, and perhaps meet performance quality measures. Further, they may be required to use a single enrollment form and a standard format for presenting health benefit plan options.
  
  o It is estimated that 3 million children will gain dental benefits through the health insurance exchanges by 2018.

Since the implementation process began in earnest, the ADA and constituent dental societies have stressed in communications with federal and state authorities, respectively, the following key advocacy points.

**ADA Position:** Exchanges must maximize competition among plans to ensure that the exchange marketplace is competitive on January 1, 2014 and beyond. To meet this goal plans must offer real value and provide consumers with an adequate network of providers.
- **Status:** Although regulators have been receptive to our message, only after the exchanges have been operational for some time will we know the true nature of the plan offerings and the adequacy of their networks.

**ADA Position:** The ADA is concerned with the way federal regulators have interpreted the ACA resulting in the pediatric dental EHB coverage purchased inside the exchange being treated differently from the same dental coverage purchased outside the exchange.

- **Status:** In a February 20, 2013, final rule from the Department of Health and Human Services (HHS), the agency stated that consumers (including those with dependents) do not have to purchase the pediatric dental EHB if the purchase is made inside the exchange. However, for purchases outside the exchange in the individual and small group markets the benefit must be purchased. The ADA believes states have the authority to require the purchase of the pediatric dental EHB inside the exchange, notwithstanding the HHS decision.

**ADA Position:** Stand-alone dental plans and medical plans with an embedded dental benefit must be able to compete on an equal footing inside and outside the exchange to ensure consumers have a robust selection of dental products.

- **Status:** HHS officials have made accommodations for stand-alone dental plans to compete inside the exchange by making it clear that medical QHPs do not have to offer the pediatric dental EHB if there is a stand-alone plan in the exchange. However, HHS does not require the medical QHPs inside the exchange offering an embedded pediatric dental EHB to separately price and offer that benefit.
  - HHS’s February 20 rule also accommodated stand-alone dental plans operating outside the exchange in the individual and small group markets. The rule allows medical QHPs outside the exchange to offer plans without the pediatric dental EHB – if the medical QHP is “reasonably assured” that such coverage is sold only to consumers who have also purchased a pediatric dental EHB through an exchange-certified stand-alone plan.

**ADA Position:** Children should be covered by a dental benefit that is “necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions” and necessary to address a health condition where both medical and dental care is clinically required.

- **Status:** All states except Utah (which is offering only preventive services) have chosen either the state’s Children’s Health Insurance Program (CHIP) plan or the MetLife High Option plan from the Federal Employee Dental and Vision Insurance Program (FEDVIP) as their benchmark plan. Both plans provide an adequate array
of dental services. HHS defined “pediatric services” as services for individuals under the age of 19, although states have the flexibility to extend such coverage beyond the 19-year-old baseline.

**ADA Position:** There should be adult dental coverage for emergencies as part of the EHB package.
- **Status:** This recommendation was not adopted by any of the state or federal regulators. It is important to note that states expanding coverage in this fashion would have to pay 100 percent of the cost.

**ADA Position:** There should be cost sharing equitability to ensure consumers are treated fairly regardless of whether they select dental coverage as part of an embedded dental product or in a separate stand-alone plan.
- **Status:** We addressed this in comments submitted to relevant federal agencies on December 19, 2012, and again on March 15, 2013. There is also an effort underway to bolster this advocacy through Congressional support.

**Health Care Delivery and Financing**

A major goal of the ACA is to better integrate and coordinate health care delivery and financing by expanding the level of health care provided under an Accountable Care Organization (ACO) umbrella. ACOs are designed to align provider incentives with provision of quality and coordinated care and to shift reimbursement away from volume of services toward health outcomes and quality. ACOs are also meant to improve the infrastructure underlying care delivery.

- **Status:** To date, the ACO models that have emerged have largely focused on health care services for the Medicare population. Expert analysis indicates that there are very few ACO type models of care that include any dental services, except for a proposed Medicaid pilot program in Oregon. The ADA is working with the Oregon Dental Association in closely monitoring the Oregon initiative.

**Certification and Accreditation**

ADA staff spoke with officials at the Center for Consumer Information and Insurance Oversight (CCIIO) about the potential certification and accreditation of stand-alone dental plans.

- **Status:** The agency agrees with the ADA that certification standards do not apply to stand-alone dental plans at this time. Also, the agency agrees that there is currently no entity authorized to engage in such activity. Going forward, CCIIO will continue to work with the ADA. We explained that the ADA has taken the lead in developing the Dental Quality Alliance (DQA) to ensure that specific concerns of dentistry are adequately addressed and
that we believe any entity designated as an accreditor for dental benefit plans should be required to use specific clinical quality measures developed by the DQA.

**Dentist Employers**

The ACA does not require small businesses with 50 or fewer employees to provide health insurance. More than 99 percent of dental practices have 50 or fewer employees.

Small business employers who pay at least 50 percent of the premium for employee coverage may qualify for a small business tax credit. To qualify, the employer must have fewer than 25 full-time equivalent employees whose average annual wage does not exceed $50,000 per employee. The tax credits, which disappear after 2016, will be available on a sliding scale to assist the purchase of health insurance.

**Taxes and Limits on Tax Preferred Accounts**

Flexible spending accounts allow employees to set aside tax-free money to pay medical and dental bills. Starting in 2013, the FSA set-aside will be limited to $2,500 a year and increased annually by a cost-of-living adjustment.

The ADA continues to support repeal of ACA provisions that are inconsistent with Association policy. This includes the 2.3 percent medical device excise tax that took effect on January 1, 2013. As the Association continues to work on repeal, the ADA has communicated with Internal Revenue Service officials and filed comments on an IRS final rule in an effort to clarify details of the new tax. In ADA News articles and other means of communications, the ADA stated that manufacturers, not dentists, will be responsible for paying the tax but that dentists will likely see an increase in their costs. Details are available on [www.ada.org](http://www.ada.org).

In 2013, there is 0.9 percent payroll surtax on wage and salary income over $200,000 for single filers or $250,000 for joint filers. The 2012 Medicare Hospital Insurance (Part A) tax for the Medicare Hospital Insurance (HI) Trust Fund is 1.45 percent of all salary income, with an equal 1.45 percent paid by employers. Starting January 2013, the tax will be 2.35 percent on all earnings above $200,000 and $250,000 respectively. For the self-employed, the rate increases from 2.9 to 3.8 percent.

There is also a 3.8 percent tax in 2013 on some investment income of taxpayers whose modified adjusted gross income exceeds $200,000 for single and $250,000 for joint filers. Investment income includes rents, dividends, interest, royalties and capital gains on property sales (with a partial exclusion for primary residence sales).
Dentists as Consumers

Plans in the individual and small group market are prohibited from imposing pre-existing condition limitations, excessive waiting periods, and copayments or deductibles for certain preventive services. Coverage must also be guaranteed issue, provide for guaranteed renewability, and plans are prohibited from rescinding coverage. Plans will be allowed to use age, tobacco use, where someone lives, and family composition to calculate premiums as well as coverage for dependents up to age 26.

Public Health Infrastructure

ACA provisions consistent with Association policy include:

- increased funding for public health infrastructure, including Centers for Disease Control and Prevention oral health programs and national oral health surveillance programs;
- additional funding for school-based health center facilities;
- increased grant opportunities for general, pediatric or public health dentists;
- funding for National Health Service Corps loan repayment programs;
- CDC initiation, in consultation with professional oral health organizations, of a five-year national public education campaign focused on oral health prevention and education.

Many of these new programs have not been funded.

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