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Affordable Care Act and oral health: ADA analysis of impact

The "Patient Protection and Affordable Care Act," shorthanded as the ACA and as this report will refer to it, has the potential to reshape health care in America. Expansion of medical insurance coverage, a move toward more integrated care delivery and significant changes in the financing of health care are among the expectations of ACA legislators and regulators. The Association's primary focus has been the law's potential effects on dentistry and the delivery of dental services to patients.

Introduced by ADA President Dr. Robert A. Faiella, this first in a continuing series of ADA News Q-and-A sessions is intended to update information on certain aspects of the ACA and its potential effects on dentistry and the oral health of the American public. This series begins with some preliminary questions regarding ACA implementation and a short retrospective look.

Additional Q-and-A reports will follow and will look ahead to potential effects of the ACA in 2014 and beyond. Going forward, it is important that the Association answer questions of most concern to members. To facilitate this dialogue, the Association invites ACA implementation questions at the dedicated healthreform@ada.org email address.

Preliminary questions regarding ACA implementation

What are some of the key provisions of the ACA?

"Of course, the primary focus of policymakers was on the medical/hospital delivery system but a number of provisions will directly impact dentistry and it is very likely that changes in the larger delivery and payment systems will have ripple effects on dentistry in the future," Dr. Faiella said in a statement introducing this series. (See story, this page.) For example, many of the systemic changes, such as paying for outcomes and not procedures and adopting health information technology (such as electronic health records), are directed at medicine but may affect dentistry at some point.

A primary goal of the ACA is to increase health insurance coverage by expanding Medicaid and establishing health benefit exchanges, which are intended to facilitate the purchase of private sector coverage by small businesses and individuals who lack coverage. An estimated 3 million children will gain private sector dental benefits through the health insurance exchanges by 2018. The ACA provides for expanding Medicaid to "newly eligible" adults with incomes up to 133 percent (138 percent, net of income disregards) of the federal poverty level: $15,282 for an individual, $31,322 for a family of four. The federal government is obligated to pick up 100 percent of the cost of covering this additional population initially and 90 percent long term.

First in a series of articles

The expansion of Medicaid coverage will vary significantly depending on how states respond to the Supreme Court ruling that the federal government cannot withhold all federal Medicaid funds from states that refuse to expand their programs. There is no requirement to provide dental services to newly eligible adults but states have the option to add those services at their discretion. If all the states expand their Medicaid programs along lines called for by the ACA, up to 3.2 million more children and 4.5 million adults could have access to extensive dental benefits, according to an Association-contracted study. At publication, 23 states and the District of Columbia have indicated they will participate in the expansion with several others leaning toward participation or looking for alternative ways of participating.

ACA provisions that authorize increased funding for public health infrastructure and prevention programs are consistent with Association policy. But many of these new programs had not been funded as this report was written.

What are health benefit exchanges?

Health benefit exchanges, or health insurance marketplaces as they are described by regulators, will be available in each state, the District of Columbia and the territories to help individuals and small businesses (up to 100 employees) buy private sector coverage. The marketplaces will be accessible online, and consumers should have access to navigators to help them make informed plan selections. Exchanges must begin enrolling beneficiaries by Oct. 1 and be fully operational by Jan. 1, 2014. Initially, the exchange will be available only to individuals and small businesses. Plan designs and premiums will vary by state. People with incomes from 100-400 percent of the federal poverty level are eligible to receive tax credits to subsidize their coverage through the exchange.

As of Jan. 1, 2014, all plans participating in the exchange (and in the individual and small group markets outside the exchange) must meet

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ACA- and state-established standards to become qualified health plans (QHPs) except for stand-alone dental plans. In general, all QHPs must offer an essential health benefit (EHB) package defined by the ACA to include pediatric dental coverage among 10 service categories. However, 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. This and future ACA reports will have more to say about the effects of this coverage dichotomy.

What is the status of the formation of health benefit exchanges or marketplaces?

In an effort to meet the October deadline of having exchanges open to accept applications, the Obama administration launched a consumer-focused website, HealthCare.gov, to help consumers understand their coverage choices. The administration's goal is to ensure that consumers will be able to create accounts, complete online applications and shop for qualified health plans through this website. As of July, 16 states and the District of Columbia planned to operate their own state-based exchanges; seven will partner with the federal government; and 27 will rely on the federal government to run federally facilitated exchanges.

What exchange issues most concern the ADA?

The ADA believes exchanges must maximize competition among plans with dental benefits. Plans must offer real value and provide consumers with an adequate network of providers. "Although federal 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," said Dr. Faiella.

The Association also is concerned with the way federal regulators have interpreted the law. On the one hand, regulators say consumers, including those with children, do not have to purchase the pediatric dental benefit if the purchase is made inside the exchange. Yet, outside the exchange (in the individual and small group markets), everyone, including families without children, must purchase a pediatric dental benefit. This may cause a great deal of confusion for purchasers. "The ADA disagrees with the federal government's interpretation and believes it is inconsistent with congressional intent and that it is also bad public policy," said Dr. Faiella. It is bad public policy because it treats dental coverage inside the exchange differently from coverage outside the exchange in the individual and small group markets.

How are dentist employers affected?

The ACA does not require small businesses with less than 50 full-time equivalent employees to provide health insurance. More than 99 percent of dental practices have less than 50 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, an employer must have less than 25 full-time equivalent employees whose average annual per-employee wage does not exceed $50,000. The tax credits, which disappear after 2016, will be available on a sliding scale to assist with the purchase of health insurance. For example, a business with 10 or less employees and $25,000 or less in average wages will receive a credit of 50 percent. Adding to controversy around this issue, the administration recently announced that it will delay until 2015 a requirement that employers with 50 or more full-time employees offer insurance.

How are dentists as health care consumers affected?

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 be guaranteed issue and provide for guaranteed renewability and plans are prohibited from rescinding coverage. Plans may use age, tobacco use, where someone lives and family composition to calculate premiums and must offer coverage for dependents up to age 26.

What are some of the key "revenue raisers" in the ACA that might affect dentistry?

There are a number of new taxes and ACA tax code changes intended by Congress to help pay for implementation including several with dental relevance.

• 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 Jan. 1. Association advocacy includes support for congressional repeal efforts and, on the regulatory side, communications with Internal Revenue Service officials and comments on IRS regulations implementing the new tax. In ADA News articles and other communications, the Association has pointed out that manufacturers, not dentists, will be responsible for paying the tax but that dentists will likely see tax-related cost increases. See for example "One Step Closer to Medical DeviceTax Repeal (But Miles to Go)" at the ADA advocacy website, ADA.org/advocacy.

• Flexible spending accounts allow employees to set aside tax-free money to pay medical and dental bills. The FSA set-aside was limited to $2,500 a year in 2013 to increase annually by a cost-of-living adjustment;

• 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 Trust Fund is 1.45 percent of all salary income with an equal 1.45 percent paid by employers. Starting in January, the tax is 2.35 percent on all earnings above $200,000 and $250,000 respectively. The rate for the self-employed increased 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).

A Retrospective Look

Where was the ADA when health reform legislation was first being discussed?

Very early in 2009, the ADA communicated to all members of Congress and the Obama administration the ADA's belief that a relatively small government investment in meeting three goals can contribute to significant improvement in the oral health of Americans.

• mend the tattered Medicaid safety net by improving the dental Medicaid program;

• adequately fund proven oral disease prevention programs;

• rebuild the dental public health infrastructure, which includes recruitment and retention of dentists competent in public health practice.

How did the ADA respond as legislation developed?

As various House and Senate committees assembled the legislative parts within their jurisdictions, it became apparent the ultimate legislative package would be far reaching. "We made a decision very early to be engaged in the process to ensure we had a voice in the debate, and it's a good thing that we did because some of the early proposals could have been especially problematic," Dr. Faiella said.

The ADA used its grassroots network and lobbying staff to address a multitude of issues. For example, during the August 2009 congressional recess the ADA asked members to meet with lawmakers and attend town hall meetings. In talking points the Association developed for participants, we said the ADA opposed a proposed government-run insurance plan that would compete with private insurers. We also said that:

• additional funding is needed for Medicaid dental services;

• consumers deserve insurance protections that ensure health care value and transparency;

• the McCarran-Ferguson antitrust exemption for the business of insurance should be repealed;

• more needs to be done on prevention and public health investment;

• the ADA opposes the revenue raisers in the legislation.

As an employer mandate was proposed, we emphasized the need for a small business exemption and a stronger medical liability reform. We also objected to the $2,500 cap on Health Flex-

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ible Spending Arrangements and the 2.3 percent medical device tax. In short, the ADA's focus at the time was on improving access to dental care for those most in need as the appropriate goal of oral health provisions in any health care reform bill. We supported provisions that moved us toward that goal and opposed provisions that conflicted with ADA policy and were inconsistent with our stated goals.

Did the ADA endorse the ACA?

The ADA did not endorse the ACA passed in March 2010 because it did not include provisions to improve access to dental care for millions of Americans by properly funding Medicaid dental services. It is by that measure that we assessed all major health care reform proposals under consideration as to whether they would have a major, positive impact on the oral health of Americans.

What has the ADA done to represent the profession and our patients as ACA implementation began in earnest?

Despite the fact that the ACA fell short of the ADA's goal of properly funded Medicaid dental services, the Association worked hard to ensure members' interests are addressed as the law takes effect in stages. "The federal agencies responsible for ACA implementation did not engage in any significant rule making immediately but once the process began we made sure we were at the table meeting with the key decision makers," Dr. Faiella said. "Even though the Association's seasoned staff has excellent contacts, we took the extra precaution of hiring outside consultants to specifically help us deal with key regulators so that we had ongoing intelligence on the process."

In early 2011, the Association had an initial opportunity to comment on the implementation process, and we continue to offer advice and comments as the ACA regulations and agency guidance are released. An overarching goal of ADA advocacy with federal officials is to ensure a consumer friendly oral health benefits market in each state. The Association's message to the regulators is this: Dental experts should provide recommendations on dental issues. The ADA supports an environment where dental benefits, whether offered as stand-alone plans or dental riders to medical plans, can adequately compete and offer consumers options for accessing oral health care. Consumers should be able to easily understand their choices based on price, quality, provider network adequacy and other factors.

What has the ADA done to help constituent dental societies advocate on behalf of their members with regard to the state's role in ACA implementation?

Understanding that many decisions about health benefit exchanges will be decided at the state level, the ADA in November 2011 contracted with the consulting firm Leavitt Partners, LLC to help develop materials for use by constituent dental societies. The ADA and Leavitt continue to host conference calls with state dental society staff and dental leaders to address ACA implementation at the state level. Extensive materials, including tool kits with general and state-specific information, were developed. ■

ADA ready to answer questions from members

Members have questions as the Affordable Care Act takes effect. The Association has answers.

To enable that conversation, the Association:

- initiated an ACA question-and-answer series in this issue of the ADA News;
- dedicated an email address, healthreform@ada, for ACA implementation questions.

Member questions will inform the continuing Q-and-A series. The ADA News will also continue to report on implementation of the many-faceted Affordable Care Act, including the related report in this issue on the Aug. 1 effective date of ACA "Sunshine Act" provisions. ■

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Sunshine Act update

CMS urged to delay data collection under ACA

Washington—Rep. Nydia Velazquez, D-N.Y., urged the Centers for Medicare & Medicaid Services July 18 to delay 'transfer of value' data collection from physicians and teaching hospitals, including dentists, scheduled to begin Aug. 1 under the Affordable Care Act.

The ACA "Sunshine Act" final rule requires manufacturers and distributors of drugs, devices, biological or medical supplies covered under Medicare, Medicaid and the Children's Health Insurance Program to report financial transactions and transfers of value to covered recipients and to begin collecting data Aug. 1 for reporting these transfers of value. This information will be reported to the CMS by March 31, 2014, for release on a public website by Sept. 30, 2014.

Dentists should be aware of possible manufacturer or distributor inquiries toward the required reporting of Sunshine Act transfers of value, including certain payments, entertainment costs, gifts, meals and travel costs. See also the ADA News March 4 'transfer of value' report, which is also posted at ADA.org/news/8262.aspx. Rep. Velazquez, ranking member of the House Small Business Committee, expressed "serious concerns" with the Feb. 1 final rule as amended and "the short timetable" for compliance.

In a letter drafted with Association assistance, Rep. Velazquez told the Obama administration that "CMS should be assisting professional associations to ensure physicians, manufacturers and distributors are provided ample time to understand the impact of the amended rules on their members. This extension will ensure the affected parties are provided accurate guidance so they can comply with the law.

"Proper implementation is a challenge because the professional community consists of many small businesses that need to be duly informed prior to any implementation of the requirements. With solo practitioners making up nearly 70 percent of all dental practices, many lack the time and resources to dedicate towards researching the new rules. The burden of compliance, from implementing proper recordkeeping to correct reporting, will harm the 92 percent of small manufacturers in the dental industry because uncertainty remains in the final rules."

In many respects the regulations are "vague and provide insufficient guidance for professionals, manufacturers and distributors," Rep. Velazquez said in the letter to CMS, which is charged with issuing the lion's share of the regulations necessary to implement the Affordable Care Act.

"Given the lack of clarity and the possible adverse impact on patient interests, I respectfully urge CMS not to implement the final rule until adequate time has been allowed for the agency to address these specific issues, provide much needed clarification and for all affected parties to receive the education necessary to ensure proper implementation," Rep. Velazquez wrote. "I look forward to working with you as CMS implements the Sunshine Act." ■

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Dr. Faiella introduces ACA Q&A

The Patient Protection and Affordable Care Act has the potential to reshape health care in America. The ADA was there in 2009 when "health care reform" consisted of just a few proposals, and we have remained involved in the legislative process and, more recently, the implementation phase. The Association's primary focus has been ACA's potential effects on dentistry and the delivery of dental services to our patients.

Dr. Faiella

The ACA rollout will continue well into the future with the formation of health benefit exchanges (or marketplaces) and adjustments to the system at federal and state levels. Expansion of medical insurance coverage, a move toward more integrated care delivery and significant changes in health care financing are expected.

In this edition of the ADA News, we are offering the first in a series of Q-and-A sessions on the ACA and its potential effect on dentistry and the oral health of the American public. We begin with some preliminary questions regarding ACA implementation and a short retrospective look.

Additional Q-and-A articles will be published on a regular basis. We will look ahead to potential effects in 2014 and beyond. Going forward, it is very important that we answer the questions of most concern to you, our members.

To facilitate this dialogue, please send any ACA implementation questions to the following email address: healthreform@ada.org. We will do our best to answer your questions and share that information in subsequent Q-and-A articles.

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