

Potential Effects of the Affordable Care Act on Dentistry

The Affordable Care Act 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. Several aspects of the ACA have important implications for dentists as oral health care professionals and small business employers, as well as consumers of medical care. While much of the effect of the ACA on health care in general and on dentistry in particular remains uncertain at this stage, it is important to highlight some of the potential changes that are likely to occur.

Medicaid

The ACA provides for the expansion of Medicaid to cover people with incomes below 133 percent (138 percent, net of income disregards) of the federal poverty level (FPL). The federal government will 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. According to various policy experts, the number of children and non-elderly adults added to the Medicaid rolls could be as high as 24 million or as low as 11 million, depending how many states accept the ACA money and expand their Medicaid program. Actual increases in monthly enrollment will likely be lower than these numbers because of the frequency with which beneficiaries enter and leave Medicaid as their financial circumstances change.

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 Organizations (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. To date, the ACO models that have emerged have largely focused on health care services for the Medicare population. Expert analysis recently completed indicates that there are very few ACO type models of care that include any dental services. Looking forward, it is uncertain when and to what degree ACOs will integrate dental care delivery and reimbursement as part of the core health care services they provide.

The ADA has taken the lead in developing the Dental Quality Alliance to ensure that specific concerns of dentistry are adequately addressed. The Association is likewise engaged with federal health information technology officials to represent dentistry's interests.

Health Insurance Exchanges

Exchanges must be in place in time to begin enrolling beneficiaries by October, 2013. Initially, the exchange will be available to individuals and small businesses only allowing the purchasers to select from various private health care plans. Under the ACA, people with incomes between 100-400 percent of the FPL are eligible to receive federally subsidized coverage through the exchange.

A key aspect of the ACA is the individual mandate to obtain health insurance covering 'essential' health benefits. The law includes pediatric dental care in a list of essential health benefits to be provided by small and individual group health plans but dental care for adults is not included in that essential benefit package.

To ensure a consistent level of consumer protections, stand-alone dental plans must offer the pediatric oral essential health benefit 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 benefits plan options.

It is estimated that 3 million children will gain dental benefits through the health insurance exchanges by 2018, or roughly a 5% increase over the current number of children with private dental benefits. It is important to note that a significant portion of children will also gain dental benefits outside of the health insurance exchanges through, for example, employer-sponsored dental benefits with dependent coverage, although the number is uncertain at this time. The effects for dentistry could be significant if, for example, the ACA-required essential pediatric dental benefit is inadequate or too expensive or if plans with inadequate dental networks dominate the exchange marketplace.

The ADA offers advocacy materials and shares best practices with constituent dental societies to encourage maximum competition in the exchanges that gives consumers a real choice of benefit plans with robust dental networks. Case studies are shared with constituents on how a state society can ensure an adequate essential dental benefit for children (California), advocate for maximum competition within the exchange that includes stand-alone plans and plans with embedded dental benefits (Washington state and Colorado), and determine whether to include adults as an add-on to the essential benefit package (Vermont).

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 scheduled to take effect Jan. 1, 2013. The ADA and members of the Organized Dentistry Coalition have opposed implementation of the tax, and the U.S. House of Representatives has passed legislation, which is stalled in the Senate, to eliminate the tax. The coalition estimates that the tax will increase the cost of dental care by more than \$160 million annually. The IRS has yet to issue final regulations.

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 Health Care Coverage Consumers

Plans in the individual and small group market could include prohibitions on refusal to cover pre-existing conditions, excessive waiting periods, copayments or deductibles for certain preventive services and on coverage rescissions, and comprehensive coverage, guaranteed issue and renewability, premium rating

limits on rate increases based on age, gender or health condition and required 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. The ACA also authorizes federal spending to support a state alternative provider demonstration project, which is inconsistent with Association policy. Money has not been appropriated by Congress to support the demonstration.