



Overview of Health Care Reform

Impact on General Dentistry and Small
Businesses

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Overview

On Sunday, March 21, the House of Representatives passed by a vote of 219 – 212 health care reform legislation previously passed by the Senate on December 24, 2009 by a vote of 60 – 39. The Patient Protection and Affordable Care Act (H.R. 3590) was signed into law by President Obama on Tuesday, March 23 and became Public Law 111-148. A “corrections” bill designed to alter P.L. 111-148 to make it more palatable to House Democrats per an agreement with Senate Democrats and President Obama also passed the House on Sunday, March 21 by a vote of 220 – 211. The “corrections” legislation, known as the Health Care and Education Affordability Reconciliation Act of 2010 (H.R. 4872), was debated in the Senate under reconciliation rules (meaning it could not be filibustered) and passed the Senate on March 25 by a vote of 56 – 43 with minor changes. The House subsequently passed the amended measure later that same day by a vote of 220 – 211. President Obama signed the bill into law on March 31 and it became Public Law 111-152.

Collectively, P.L. 111-148 and P.L. 111-152 total well more than 2,500 pages. The health care reform measures contain several provisions that impact and/or are of interest to general dentists and small business owners.

The legislation has ten titles:

- *Title I: Quality, Affordable Health Care for All Americans* – Fundamentally alters the manner in which health insurance is regulated in the United States by creating federal standards for health plans, establishing federal oversight of the issuance and purchase of health insurance, and creating new marketplaces, individual and employer responsibilities / mandates, assistance programs for qualifying individuals and small businesses, and punitive fines for individuals and employers that fail to meet certain obligations to purchase insurance.
- *Title II: Role of Public Programs* – Makes several changes to the Medicaid and Children’s Health Insurance Program (CHIP) to expand access and services.
- *Title III: Improving the Quality and Efficiency of Health Care* – Implements significant changes to several of the formulas through which Medicare reimburses providers in order to reduce federal expenditures and establishes new reporting requirements.
- *Title IV: Prevention of Chronic Disease and Improving Public Health* – Creates several new prevention and wellness programs and expands several public health and community-based health programs.
- *Title V: Health Care Workforce* – Significantly alters existing health workforce and education and training programs, including those authorized by Title VII and Title VIII of the Public Health Service Act, and creates new health workforce programs.

- *Title VI: Transparency and Program Integrity* – Creates new reporting requirements for physicians, establishes federal oversight for nursing homes, and enhances programs aimed at combating waste, fraud, and abuse in government health care programs.
- *Title VII: Improving Access to Innovative Medical Therapies* – Establishes a process under which generic biological products can be licensed by the Food and Drug Administration (FDA); expands the 340B program under which certain prescription medications are sold at a discounted rate to qualifying providers.
- *Title VIII: Community Living Assistance Services and Supports* – Establishes a new, voluntary, self-funded public long-term care insurance program (the CLASS program) to pay cash benefits to qualifying individuals with functional limitations for the purchase of community living assistance services and supports.
- *Title IX: Revenue Provisions* – Establishes several new taxes and fees to fund the availability of health care coverage to uninsured individuals and the expansion of public health, prevention and wellness, and health workforce programs.
- *Title X: Strengthening Quality, Affordable Health Care for All Americans* – Makes alterations to the previous nine titles and adds additional provisions, including a wholesale reauthorization of the Indian Health Care Improvement Act.

General Summary of Insurance Reforms

In general, H.R. 3590 / 4872 fundamentally alters the manner in which health insurance is sold, purchased, and regulated in the United States. The measure:

- Creates new Federal consumer protections for purchasers in the individual and small group markets –
 - Prohibits exclusion for pre-existing conditions
 - Limits the variance of premiums charged within a service area to age and tobacco use and restricts the variance permitted
 - Establishes guarantee issue and guarantee renewal
 - Prohibits lifetime and annual limits
 - Prohibits rescission except in the cases of fraud
 - Requires coverage without cost sharing for preventive services graded A or B by the U.S. Preventive Services Task Force
 - Requires insurers to provide coverage to dependent children up to the age of 26
 - Requires the development of universal “explanation of coverage” documents
 - Prohibits discrimination based on salary
 - Requires insurers to meet specific medical loss ratios (i.e., only a certain percentage of premium revenue may go to items other than payment of benefits)
 - Requires qualified plans to meet certain minimum requirements.

- Establishes within 90 days of enactment a temporary high-risk insurance programs for uninsured individuals with preexisting conditions and a reinsurance program for individuals aged 55-64 – the programs expire in 2014;
- Establishes state-based “American Health Benefit Exchanges” beginning in 2014 to act as a virtual marketplace for individuals and small groups;
- Mandates a minimum benefits package for policies being sold on the exchanges – “essential benefits” include:
 - Ambulatory patient services
 - Emergency services
 - Hospitalization
 - Maternity and newborn care
 - Mental health & substance abuse disorder services, including behavioral health treatment
 - Prescription drugs
 - Rehabilitative and habilitative services and devices
 - Laboratory services
 - Preventive and wellness services and chronic disease management
 - Pediatric services, including oral and vision care;
- Establishes guidelines on actuarial equivalence for various levels of coverage sold on the exchanges:
 - Bronze Level – 60 percent actuarial value
 - Silver Level – 70 percent actuarial value
 - Gold Level – 80 percent actuarial value
 - Platinum Level – 90 percent actuarial value;
- Requires the Secretary of Health and Human Services to award loans for start-up costs to establish nonprofit, member-owned health insurance cooperatives;
- Requires the federal Office of Personnel Management (OPM) (which oversees the Federal Employee Health Benefits Program) to contract with non-profit insurers to provide at least two “multi-state qualified health plans” on each state’s Exchange;
- Permits states to establish state-run insurance plans for individuals that are not eligible for Medicaid but earn less than 200 percent of the federal poverty level (FPL);
- Creates new mandates for individuals and employers:
 - Mandates that individuals obtain some form of health insurance and establishes punitive fines for failure to secure coverage – the fines phase in up to a maximum of \$695 or 2.5% of income, whichever is higher;
 - Provides tax credits for lower-income individuals and families up to 400 percent of FPL to assist in the paying of premiums and cost sharing;
 - Requires larger employers (greater than 50 employees) that do not offer health coverage, or contribute less than 60 percent of the cost of health coverage, and have at least one employee earning the premium tax credit, to pay a fine equal to \$2,000 for each employee, though the first 30 employees are excluded from the calculation;
 - Provides tax credits to very small businesses to assist in the purchasing of health insurance for their employees;
- Expands Medicaid coverage to cover those individuals with income under 133 percent of the FPL.

Provisions of Interest to the AGD

There are several provisions of interest or concern to general dentists as health care providers and small business owners:

Dental and Oral Health Provisions

There are several dental and oral health related provisions in the legislation, including insurance-related provisions, prevention and public health provisions, and health workforce provisions.

Insurance-Related Provisions

Essential Health Benefits Requirements

A “qualified health plan” eligible to participate in the Exchanges per the legislation must contain “essential health benefits” within several general categories of items and services, to include: “pediatric services, including oral and vision care.” The term “pediatric” is not defined by the legislation. The legislation contains no mention of adult dental care or adult oral health care.

The legislation requires the Secretary of Health and Human Services (HHS) to define the essential health benefits within the prescribed categories, including pediatric oral care. The Secretary shall submit a report to the appropriate committees of Congress containing a certification from the Chief Actuary of the Centers for Medicare and Medicaid Services (CMS) that the essential benefits are equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary with assistance from the Secretary of Labor, who must conduct a survey of employer-sponsored coverage to determine the benefits typically covered. The Secretary of HHS must provide notice and an opportunity for public comment in defining and revising the essential health benefits.

Standalone Dental Benefits

The legislation requires each State to permit limited scope dental benefit plans to be offered through its Exchanges, either separately or in conjunction with a qualified health plan, so long as the plan provides pediatric dental benefits meeting the requirements of the essential health benefits established by the legislation and the Secretary of HHS.

The bill establishes specific rules and carve-outs for the dental-only plans, including:

- Exempting the dental-only plans from the comprehensive coverage requirements imposed on other qualifying health benefits plans eligible to be offered through the Exchanges;
- Permitting health plans that do not offer required pediatric oral health benefits to qualify nevertheless for participation in an Exchange if that Exchange contains a dental-only plan that offers the required pediatric oral health services; and
- Permits the portion of a beneficiary’s premium payment to a dental-only plan that is allocable to the required pediatric oral health services to be treated as a premium payable

for a qualified health plan for the purposes of determining the level of Federal support via the premium assistance tax credit for qualifying individuals.

Medicaid and CHIP Payment and Access Commission (MACPAC)

The Medicaid and CHIP Payment and Access Commission (MACPAC) was established by the Children’s Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Its duties are to review policies of the Medicaid and CHIP programs affecting children’s access to covered items and make recommendations to Congress concerning such access policies. It is designed to be the Medicaid / CHIP equivalent of the Medicare Payment Advisory Commission (MedPAC).

The health reform legislation amends the MACPAC statute to clarify that one of the specific topics to be reviewed and assessed by MACPAC (as part of its duty to assess payment policies, including factors affecting expenditures for items and services in different sectors) is the process for updating payments to dental professionals. The legislation states that MACPAC must assess the relationship of such factors and methodologies to access and quality of care for beneficiaries, including how they enable beneficiaries to obtain services for which they are eligible, affect provider supply, and affect providers that serve a disproportionate number of low-income and other vulnerable populations.

The legislation also reconfirms that dentists shall be included among the 17 members of MACPAC. Members are appointed by the Comptroller General of the United States, the head of the Government Accountability Office (GAO).

Medicare Advantage

Medicare Advantage is a program that pays private plans to provide Medicare services to Medicare beneficiaries as an alternative to the federally administered fee-for-service (FFS) Medicare program. Medicare Advantage plans are paid more than the cost of care for beneficiaries in the FFS program and may use these additional payments to provide extra benefits that are not available under FFS Medicare, including (in some cases) dental benefits.

The health reform legislation makes several changes to the Medicare Advantage program, including prescribing the priority by which extra benefits may be provided to beneficiaries. The bill requires extra benefits to go first towards cost-sharing reductions, second towards wellness and preventive care, and third to other benefits not available through FFS Medicare, including eye examinations and dental coverage.

Public Health and Prevention and Wellness Programs

Public Oral Health Programs

The legislation creates various oral health care prevention measures. It establishes a new “Part T” within Title III of the Public Health Service Act that is entitled, “Oral Healthcare Prevention Activities”. This Part includes two new programs:

Oral Health Care Prevention Education Campaign

The Secretary of HHS, acting through the Director of the Centers for Disease Control and Prevention (CDC) and in consultation with professional oral health organizations, shall establish a national public education campaign that is focused on oral health care prevention and education, including prevention of oral disease such as early childhood and other caries, periodontal disease, and oral cancer. The campaign is to begin two years after enactment and last for five years. It must target specific populations such as children, pregnant women, parents, the elderly, individuals with disabilities, and ethnic and racial minority populations in a culturally and linguistically appropriate manner. The campaign must use science-based strategies to convey oral health prevention messages that include water fluoridation and dental sealants.

Research-Based Dental Caries Disease Management

The legislation requires the Director of CDC to provide demonstration grants to support programs that demonstrate the effectiveness of research-based dental caries disease management activities. Grants must be provided to community-based providers of dental services, including: Federally qualified health centers (FQHC); clinics of hospitals owned or operated by a State; State or local departments of health; dental programs of the Indian Health Service; Indian tribes or tribal organizations, or urban Indian organizations; health system providers; private providers of dental services; medical, dental, public health, nursing, or nutrition educational institutions; or national organizations involved in improving children's oral health. The Secretary of HHS shall utilize the information generated from these projects in planning and implementing its Oral Health Care Prevention Education Campaign.

School-Based Sealant Programs

The legislation requires the CDC to provide grants to each of the 50 States and Indian tribes to assist school-based dental sealant programs. Under current law, the CDC is authorized but not required make grants to States for such activities. These funds are used to enable low-income urban and rural schools to provide children with access to dental care and dental sealant services. All services must be provided by licensed dental health professionals in accordance with State license practicing laws.

Oral Health Infrastructure

The legislation requires the CDC to enter into cooperative agreements with States, territories, and Indian tribes to establish oral health leadership and program guidance, oral health data collection and interpretation (including determinants of poor oral health among vulnerable populations), a multi-dimensional delivery system for oral health, and to implement science-based programs to improve oral health, including dental sealants and community water fluoridation.

Updating National Oral Health Surveillance Programs

The legislation enhances oral health care surveillance activities. It requires the following government surveys to include oral health care data:

- The Pregnancy Risk Assessment Monitoring System (PRAMS) at the CDC must include oral health care measurements;
- The National Health and Nutrition Examination Survey (NHANES) at the CDC must include “tooth-level surveillance” (i.e., a clinical examination of where an examiner looks at each dental surface); and
- The Medical Expenditures Panel Survey (MEPS) at the Agency for Healthcare Research and Quality (AHRQ) must include the verification of dental utilization, expenditure, and coverage findings through conduct of look-back analysis.

The legislation also authorizes funding for fiscal years 2010 – 2014 to increase the participation of States in the CDC’s National Oral Health Surveillance System from 16 States to all 50 States, territories, and the District of Columbia. The System shall include the measurement of early childhood caries.

School-Based Health Centers

The legislation requires the Secretary of HHS to award grants to school-based health centers (SBHC), which are defined as health clinics that are located in or near a school facility, organized through school, community, and health provider relationships, and administered by a hospital, public health department, community health center, nonprofit health care agency, a school or school system, or by the Indian Health Service. An SBHC must provide certain health services, including “referrals to and follow up for oral health services”; all services must be performed in compliance with all state and federal laws. Grant funding may be used to acquire and lease equipment, provide training related to the provision of health care services, manage and operate the SBHC, and pay salaries.

Medical Equipment for the Disabled

The legislation establishes standards for accessible medical diagnostic equipment which will impact dentistry. Within 24 months of enactment of the legislation, the Architectural and Transportation Barriers Compliance Board (which is responsible for developing and maintaining accessibility guidelines and standards) must issue regulatory standards in consultation with the Commissioner of the FDA setting forth the minimum technical criteria for “medical diagnostic equipment”, which is defined to include examination chairs used for dental examinations and procedures, x-ray equipment, and other radiological equipment. The standards must ensure that such equipment is accessible to, and usable by, individuals with disabilities, and allow independent entry to, use of, and exit from the equipment by such individuals to the maximum extent possible.

Health Workforce Provisions

Title VII

The legislation creates a new “dental cluster” under the Title VII health professions training program to include general, pediatric, and public health dentists, and dental hygienists. Previously, general and pediatric dentists were included in a cluster with primary care medicine, public health dentists were included in a public health cluster, and dental hygienists were included with allied health professionals.

The program authorizes the Secretary of HHS to make grants to or enter into contracts with a school of dentistry, public or nonprofit private hospital, or public or private nonprofit entity to:

- Plan, develop, operate, or participate in an approved professional training program 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;
- Provide financial assistance to participants in such programs that plan to work in general, pediatric, or public health dentistry or dental hygiene;
- Plan, develop, and operate a program for the training of oral health care providers who plan to teach in general, pediatric, or public health dentistry or dental hygiene;
- Provide financial assistance in the form of traineeships or fellowships to dentists who plan to teach in or are teaching in general, pediatric, or public health dentistry;
- Meet the costs of projects to establish, maintain, or improve dental faculty development programs, and pre-doctoral and post-doctoral training, in primary care;
- Create a loan repayment programs for faculty in dental programs whereby participants agree to teach for five years in return for gradual repayment of the principal and interest on the outstanding student loans of the individual; and
- Provide technical assistance to pediatric training programs.

Grants under the program are for five years and funds may be carried over for up to three years. The bill authorizes \$30 million for the program in fiscal year 2010 and such sums as may be necessary for the subsequent five years.

Alternative Dental Health Care Providers Demonstration Project

The legislation authorizes the Secretary of HHS to award grants to establish demonstration programs whereby grantees establish training programs to train or employ “alternative dental health care providers” in rural and other underserved communities. The term “alternative dental health care provider” is defined as a community dental health coordinator, advance practice dental hygienist, independent dental hygienist, supervised dental hygienist, primary care physician, dental therapist, dental health aide, and any other dental health professional that the Secretary determines to be appropriate. Additionally, language specifically states that nothing prohibits a DHAT program from being an eligible recipient of a demonstration grant.

A total of 15 projects may be funded by the Secretary, with each funded project to receive not less than \$4 million over the five-year period of the demo. All demonstrations must commence within two years of enactment of the legislation and be completed within seven years of enactment.

Entities eligible to receive demonstration grants include institutions of higher education (including community colleges), public-private partnerships, FQHCs, Indian Health Service facilities, State or county public health clinics, or public hospitals or health systems. Each grant recipient must be within a program accredited by CODA and must certify that it is in compliance with all applicable State licensing requirements.

The Institute of Medicine (IOM) is tasked with analyzing the studies regarding access to dental health care. Its analysis must be based on “quantitative and qualitative data.”

The legislation authorizes such sums as may be necessary for the overall program, but funding must be appropriated before the program could go forward. The decision of whether to appropriate funds is at the discretion of the House and Senate Appropriations Committees.

Other Workforce Programs

National Health Care Workforce Commission

The legislation establishes a 15-member National Health Care Workforce Commission that is tasked with reviewing health care workforce and projected workforce goals in order to provide comprehensive, unbiased information to Congress and the Departments of HHS, Labor, Education, and others on how to align Federal health care workforce resources with national needs. The Commission members, who are to be appointed by the Comptroller General, will submit annual reports to Congress on:

- Health care workforce supply and distribution (including projected demands during the subsequent 10 and 25 year periods);
- Health care workforce education and training capacity (including projected demands during the subsequent 10 and 25 year periods);
- Title VII health professions and Title VIII nursing training programs;
- Implications of new and existing Federal policies which affect health care workforce (including Medicare GME, Titles VII and VIII, the National Health Service Corps, and the Workforce Investment Act);
- Health care workforce needs of special populations (i.e., minorities, rural populations, medically underserved populations, gender specific needs, individuals with disabilities, and geriatric, and pediatric populations); and
- Recommendations for creating or revising national loan repayment and scholarship programs to require low-income minority medical students to serve in their home communities if designated as a medically underserved community.

Congress will use this information when providing appropriations to discretionary programs (such as Title VII health workforce programs) or in restructuring other Federal funding sources.

Among the high-priority topics to be reviewed and assessed by the Commission is the education and training capacity, projected demands, and integration with the health care delivery system of oral health care workforce capacity at all levels.

For the purposes of the Commission, the legislation defines “health care workforce” to include dentists, dental hygienists, and other oral health care professionals. It defines “health care professional” to include dentists, dental hygienists, and representatives of schools of dentistry, and oral health industry dentistry and dental hygiene. Finally, the Commission must consult with various stakeholders in conducting its work, including small business owners and the self-employed.

Geriatric Education and Training

The legislation authorizes funding to geriatric education training centers to support training in geriatrics, chronic care management, and long-term care for faculty in health professions schools (including schools of dentistry). The provision also establishes funding to support training for family caregivers; to develop curricula and best practices in geriatrics; to expand geriatric career awards to several health professions, including dentists; and to establish traineeships for individuals who are preparing for advanced education nursing degrees in geriatric nursing.

U.S. Public Health Sciences Track

The legislation directs the Surgeon General to establish a U.S. Public Health Sciences Track to train physicians, dentists, nurses, physician assistants, mental and behavioral health specialists, and public health professionals emphasizing team-based service, public health, epidemiology, and emergency preparedness and response. Students receive tuition remission and a stipend and are accepted as Commission Corps officers in the U.S. Public Health Service with a two-year service commitment for each year of school covered. The bill requires the program to graduate at least 100 dentists annually. Priority will be given to applicants from rural communities and underrepresented minorities.

Area Health Education Centers (AHECs)

The legislation authorizes funding to establish community-based training and education grants for Area Health Education Centers (AHECs), which are academic and community partnerships that provide health career recruitment programs for K-12 students and increase access to health care in medically underserved areas. AHECs address health care workforce issues by exposing students to health care career opportunities that they otherwise would not have encountered, establishing community-based training sites for students in service-learning and clinical capacities, providing continuing education programs for health care professionals, and evaluating the needs of underserved communities. The new community-based training and education grant programs target individuals seeking careers in the health professions from urban and rural medically underserved communities. Funding under these programs shall be used for,

among other things, conducting and participating in interdisciplinary training that involves dentists.

Teaching Health Centers

The legislation directs the Secretary of HHS to establish a grant program to support new or expanded primary care residency programs at “teaching health centers”, defined as community-based, ambulatory patient care centers. For the purposes of this provision, a primary care residency program is defined as including an approved graduate residency training program in general dentistry or pediatric dentistry. Funding may be used for, among other things, accreditation by the American Dental Association (ADA).

Advisory Committee on Training in Primary Care Medicine and Dentistry

The legislation amends the duties of the Advisory Committee on Training in Primary Care Medicine and Dentistry to require that it develop, publish and implement performance measures for the programs under its purview, develop and publish guidelines for longitudinal evaluations of such programs, and recommend appropriations levels for the programs.

Community Health Centers and the National Health Service Corps

The legislation creates a new Community Health Centers Fund to provide additional funding for Community Health Centers and the National Health Service Corps. A total of \$11 billion is appropriated for Community Health Centers in fiscal years (FY) 2011 – 2015 (including \$1.5 billion for construction and renovation) and \$1.5 billion in FY 2011 – 2015 for the National Health Service Corps recruitment, scholarship, and loan repayment programs.

Small Business / Small Employer Provisions

The legislation contains many provisions related to small businesses and small employers, including those related to new employer responsibilities, a small business tax credit, small business health insurance exchanges, and small business cafeteria plans.

Employer Responsibilities

The legislation places new mandates on certain employers and establishes punitive fines for noncompliance.

Automatic Enrollment for Employees of Large Employers

The legislation requires that an employer with more than 200 full-time employees and that offers its employees enrollment in one or more health benefits plan must automatically enroll new full-time employees in an offered plan and maintain coverage for current full-time employees. Employees may opt out.

Employer Requirement to Inform Employees of Coverage Options

The legislation amends the Fair Labor Standards Act to require that all employers provide to each new employee at the time of hiring (and for current employees, no later than March 1, 2013) written notice:

- Informing them of the existence of an Exchange, the services provided by the Exchange, and the manner in which the employee may contact the Exchange for assistance;
- If the employer's contribution to its health benefits plan is less than 60 percent of such costs, that the employee may qualify for a premium tax credit and cost-sharing reductions if the employee purchases a qualified plan through an Exchange; and
- If the employee purchases a plan through an Exchange that the employee will lose the employer contribution to the health benefits plan and that such contribution may be excludable from income for Federal income tax purposes.

Responsibility for Employers Regarding Health Coverage

While the legislation technically does not impose a mandate on employers to provide health coverage to full-time employees, it does penalize large employers that fail to do so:

- If an employer with more than 50 full-time employees (defined as employees that average at least 30-hours of service per week) does not offer health coverage to its employees and at least one full-time employee is certified as purchasing individual health coverage through an Exchange and receiving a premium tax credit or cost-sharing reduction (available to individuals earning up to 400 percent of FPL), then the employer must pay a fine equal to \$2,000 per each individual employed as a full-time employee by the employer above 30 employees. (For example, an employer with 51 employees would pay a fine equal to the product of \$2,000 and 21 employees (51-30=21)).
- If an employer with more than 50 full-time employees offers coverage to its full-time employees and their dependents but at least one full-time employee is certified as purchasing individual health coverage through an Exchange and receiving a premium tax credit or cost-sharing reduction, then the employer must pay a fine equal to \$3,000 for each full-time employee receiving the tax credit.

Additionally, employers with more than 50 full-time employees must report to the Treasury Secretary whether it offers employer-sponsored health coverage to its full-time employees and dependents, the length of any applicable waiting period, the lowest cost option in each of the enrollment categories under the plan, and the employer's share of costs. The employer must also report the names of full-time employees receiving coverage.

Reporting

Beginning for tax year 2011, all employers must disclose the value of the benefit provided by the employer to the employee's health insurance coverage on the employee's annual Form W-2.

Small Business Tax Credit

The legislation provides a tax credit to very small businesses to assist them in providing health coverage to their employees. The tax credit is available to small businesses with no more than 25 employees whose employees have average annual wages of no more than \$50,000. However, the full tax credit is available only to small businesses with 10 or fewer employees whose employees have average annual wages of less than \$25,000. The credit phases out for employers with more than 10 but not more than 25 employees as well as for employers whose employees have average annual wages between \$25,000 and \$50,000. The wage requirements are to receive an annual inflationary update.

Small businesses that meet the aforementioned employee and wage criteria are eligible for the tax credit if they contribute at least 50 percent of the lesser of (1) the total premium for an employee's health coverage or (2) a small business bench mark premium. In tax years 2010, 2011, 2012, and 2013, the credit is available to any qualifying small business offering health insurance. The credit is equal to 35 percent of the small employer's qualifying contributions to health coverage for employees. Tax exempt small businesses meeting the requirements qualify for a tax credit equal to 25 percent of the contributions to health coverage for employees.

In tax years 2014 and beyond, the credit is available to any qualifying small business that purchases health insurance coverage for its employees through an exchange. The credit is available only for the first two years that the employer purchases insurance through the exchange. The credit is equal to 50 percent of the employer's qualifying contributions to health coverage for employees. Tax exempt small businesses meeting the requirements qualify for a tax credit equal to 35 percent of the contribution to health coverage for employees.

In any year, the tax credit is not payable in advance and it is not refundable; the credit is a general business credit and can be carried back for one year and carried forward for 20 years; and a qualified employer is entitled to a tax deduction equal to the amount of the employer contribution to employee health coverage minus the dollar amount of the credit.

Reporting

The legislation requires all individuals and employers to report to the Treasury Secretary on their health insurance coverage. Employers must provide information to their employees (for inclusion in the employee's report) on the employer's identification number, the portion of the premium required to be paid by the employer, and other information, such as that necessary for the administration of the small business tax credit.

Study

Not later than five years after enactment of the health reform legislation, the GAO shall conduct a study that includes an analysis of the impact of the small business tax credit on maintaining and expanding health insurance coverage for individuals.

Waiver

Under the bill, beginning in 2017, States may receive a waiver from the Secretary of HHS for all requirements and benefits in the health reform bill in return for implementing an innovative health coverage plan that meets certain criteria. Under this circumstance, any small business tax credit that would otherwise have been due to small businesses in the State would instead be paid in aggregate to the State in order to carry out its innovative health plan waiver program.

Small Employers and Health Insurance Exchanges

Definition of Small Employer

The legislation permits qualified small employers to purchase health coverage for employees through an Exchange beginning in 2014; large employers are not permitted to join an Exchange until at least 2017. The bill defines a small employer for these purposes as being an employer with 100 or fewer employees, though some states are permitted through the year 2016 to define a small employer as having 50 or fewer employees. A small employer that grows beyond 100 employees may still be treated as a small employer for the purposes of purchasing health coverage for employees through an Exchange.

SHOP Exchange

States must establish a Small Business Health Options Program (SHOP) Exchange to assist qualified small employers in facilitating the enrollment of their employees in qualified health plans offered through the small group market in the State. A State may choose not to offer a separate SHOP Exchange so long as its American Health Benefits Exchange also services qualified small employers in the State.

Support and Assistance

Several provisions of the legislation provide varying levels of support and assistance to facilitate the activities of the Exchanges as they relate to small employers.

- The Secretary of HHS is required to offer technical assistance to States to facilitate the participation of qualified small businesses in the State's SHOP Exchange.
- An Exchange must consult with several stakeholders in carrying out its activities, including representative from small businesses.
- An Exchange must award grants to eligible entities (which can include resource centers of the Small Business Administration (SBA)) to establish "navigators" that assist in facilitating engagement between an Exchange and health insurance purchasers.

Simple Cafeteria Plans for Small Businesses

The legislation establishes (beginning in 2011) Simple Cafeteria Plans that ease participation restrictions so that small businesses can provide tax-free benefits to their employees. Under this provision, self-employed individuals are included as qualified employees. Employers must make minimum contributions equal to a uniform percentage (not less than two percent) of the employee's compensation for the plan year or an amount that is not less than the lesser of six percent of the employee's compensation for the plan year or twice the amount of the salary reductions of each qualified employee.

This provision applies to employers with 100 or fewer employees. An employer that grows larger than 100 employees may continue to operate a Simple Cafeteria Plan for Small Businesses until it reaches 200 employees.

Small Business Workplace Wellness Grant Program

The legislation creates a grant program within the Department of Health and Human Services to award grants to employers with less than 100 employees in order to support comprehensive workplace wellness programs. The programs must be available to all employees and include the following: health awareness initiatives (including health education, preventive screenings, and health risk assessments); efforts to maximize employee engagements; initiatives to change unhealthy behaviors and lifestyle choices (including counseling, seminars, on-line programs, and self-help materials); supportive environment efforts (including workplace policies to encourage health lifestyles, healthy eating, increased physical activity, and improved mental health. The grant program will exist for five years after enactment.

Revenue Provisions

There are several revenue provisions in the legislation that will impact or may be of interest to general dentists as health care providers and/or small business owners.

Excise Tax on High Cost Employer-Sponsored Health Coverage

Beginning in 2018, the legislation establishes an excise tax of 40 percent on insurance companies and plan administrators for any health coverage plan that is in excess of \$10,200 for single coverage and \$27,500 for family coverage. The tax would apply to the amount of the premium in excess of the threshold and it applies to self-insured plans and plans sold in the group market, but not to plans sold on the individual market

The threshold is increased by \$1,650 for single coverage and \$3,450 for family coverage if the plan is for retired individuals age 55 and older or it covers employees engaged in "high risk" professions (i.e., police officers, firemen, emergency medical personnel, and individuals engaged in construction, mining, agriculture, forestry, or fishing).

The legislation was amended to ensure that standalone dental plans are not counted towards the taxable amount. This will address concerns that employers might have dropped dental coverage in order to avoid the excise tax.

Health Savings Accounts, Archer Medical Savings Accounts, Health Reimbursement Arrangements, and Health Flexible Spending Arrangements

The legislation makes certain changes to the tax treatment of HSAs, Archer MSAs, HRAs, and FSAs.

- Beginning in 2011, over-the-counter medications that are not prescribed will not qualify as a qualified medical expense for HSAs, FSAs, and HRAs – only medications that are prescribed or insulin will qualify.
- Beginning in 2011, the tax for HSA withdrawals prior to age 65 for purposes other than qualified medical expenses will be increased from 10 percent to 20 percent. The additional tax for Archer MSA withdrawals not used for qualified medical expenses will increase from 15 percent to 20 percent.
- Beginning in 2013, contributions to FSAs are limited to \$2,500 annually.

Fees on pharmaceutical manufacturers, medical device manufacturers, and health insurers

The legislation imposes an annual flat fee on the pharmaceutical manufacturing sector and the health insurance sector. In each case, the nondeductible fee will be allocated across the industry according to market share and would not apply to certain companies with sales below a certain threshold.

- **Pharmaceutical Fee:** The flat fee varies annually from between \$2.5 billion and \$4.1 billion and applies to branded prescription pharmaceutical manufacturers and importers. The fee goes into effect in 2011 and does not apply to companies with sales of branded pharmaceuticals of \$5 million or less. The fee also does not apply to drugs with “orphan drug” status.
- **Health Insurance Fee:** The annual fee is \$8 billion when it goes into effect in 2014 and increases annually up to \$14.3 billion in 2018. It does not apply to companies whose net premiums written are \$25 million or less or whose fees from administration of employer self-insured plans are \$5 million or less. Non-profit insurers are required to pay a fee only on 50 percent of their net premiums.
- Additionally, an excise tax is placed on medical device manufacturers and importers. The tax is equal to 2.9 percent on the first sale for use. Class I medical devices are exempted.

Modification of Itemized Deduction for Medical Expenses

The legislation increases the adjusted gross income threshold for claiming the itemized deduction for medical expenses from 7.5 percent to 10 percent beginning in 2013. Individuals that are 65 years of age or older may continue to claim the itemized deduction for medical expenses at 7.5 percent through 2016.

Additional Hospital Insurance Tax on High-Income Taxpayers

The legislation increases the Hospital Insurance (HI) payroll tax for employees (which funds the Medicare Trust Fund for Medicare Part A) from 1.45 percent to 2.35 percent on individual taxpayers earning over \$200,000 and in the case of married couples filing jointly, \$250,000. Also, a new Medicare tax is levied against net investment income for taxpayers earning over \$200,000 and couples filing jointly earning over \$250,000. The tax is equal to 3.8 percent of “net investment income”, which is defined as interest, dividends, royalties, rents, gross income from a trade or business involving passive activities, and net gain from disposition of property (other than property held in a trade or business). Net investment income is reduced by properly allocable deductions to such income.

Dental Health Aide Therapist (DHAT) Program and Other Alaska Initiatives

DHAT Program

The legislation enacts into law an update of the Indian Health Care Improvement Act (IHCIA) by reference to S. 1790 as reported by the Senate Indian Affairs Committee (SIAC). Included within this is an update the statutory authority governing the Community Health Aide Program (CHAP) in Alaska, of which the Dental Health Aid Therapist (DHAT) program is one component. DHATs are unlicensed non-dentist practitioners that are certified in Alaska to perform dental procedures without the direct supervision of a dentist after just two years of study. The bill permits tribes outside of Alaska to implement a DHAT program if the State within which the tribe resides authorizes DHATs or mid-level dental health provider services.

Interagency Task Force on Access to Health Care in Alaska

Additionally, the legislation creates an Interagency Access to Health Care in Alaska Task Force to assess access to health care for beneficiaries of Federal health care systems in Alaska and to develop a strategy for the Federal Government to improve delivery of health care to such beneficiaries. The Task Force will consist only of members of the Federal government, including representatives from the Departments of Health and Human Services, Defense, Veterans Affairs, and Homeland Security. Within six months of enactment, the Task Force must report to Congress its findings, strategies, recommendations, policies, and initiatives. The Task Force must “consider completed and ongoing efforts by Federal agencies to improve access to health care in the State of Alaska.”

Next Steps and Contact Information

Passage and enactment of health care reform legislation completes over a year of all-consuming debate in Congress on this matter. While a political effort is afoot from Republicans to try and repeal the legislation or to have it nullified by the courts, most objective observers do not believe that these efforts have much possibility of success and it is highly likely that the policies enacted will be the law of the land for the foreseeable future. The AGD will continue to closely track this matter and to engage policymakers and the legislative provisions are enacted into law.

Please do not hesitate to contact AGD's Government Relations Department at advocacy@agd.org if you have any questions about the content of this memorandum.