

Health Care Reform Legislation: Side-by-Side Comparison

November 2, 2009

Issues	Affordable Health Care for America Act H.R. 3962 (October 29, 2009 version as introduced)	Senate Bill (Bill not introduced)	ADA Comments/ Amendments
<p>Creation of an Entity to Regulate the Private Insurance Market; the Government Run Insurance Plan; Consumer Protections; Impact on Stand Alone Dental Plans</p>	<p>Individuals and small employers (beginning with firms with 25 employees in 2013; 50 employees in 2014; and 100 employees in 2015) will be able to purchase “qualified” private coverage (“Qualified Health Benefits Plans” (QHBP)) through a <i>National Health Insurance Exchange</i>. States and territories will have the option to run their own Exchange if federal standards are met. The Exchange serves as a pooling mechanism for offering private coverage (and a public insurance plan). It is also the mechanism used to administer the tax credits and for enforcing the variety of requirements placed on QHBPs. (Sec. 222; pages 104-111; Sec. 301-311; pages 155-211)</p> <p>The plans will be subject to a variety of market regulations, such as prohibition of pre-existing conditions, guarantee issue, premium rating limits, ensuring adequacy of provider networks, requiring to offer dependent coverage for uninsured young adults (under 27 years of age), etc. (Sec. 211-217; pages 95-102)</p> <p>QHBP shall establish consumer protections, including fair grievance and appeals mechanisms, information transparency and plan disclosure, timely payment of claims, standardized rules for coordination</p>		<p>ADA policy (Res. 60H) passed by the 2009 House of Delegates states the Association shall advocate for any health care reform proposal that maintains the private health care system and assures that insurance coverage is affordable, portable and available without regard to preexisting health conditions. ADA policy (Res. 33H) passed by the Association’s 2009 House of Delegates also directs the ADA to seek application of consumer protections that would apply to ERISA plans that are exempt from state consumer protection laws. ADA policy (Res. 59H) passed by the 2009 House of Delegates states the Association shall advocate for any health care reform proposal that opposes any third party contract provisions that establish fee limits for non-scheduled dental services.</p> <p>The ADA would oppose a government run insurance plan (the public option plan) that:</p> <ul style="list-style-type: none"> • required health care providers to participate, • directly or indirectly dictated fees for the private market, • would lead to a government-run health system, and • did not use market billed rates to determine

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	<p>and subrogation of benefits, and application of administrative simplification. (Sec. 231-237; pages 119-127)</p> <p>The Exchange will also offer a public insurance plan option. The Secretary will negotiate fees with providers who choose to participate in the public option plan (providers will be able to opt out of the plan). Aggregate payment rates in the public plan may not be lower than rates under Medicare or higher (in the aggregate) than the average rates paid by other qualified health benefit plans (the private sector plans) in the exchange. (Sec. 321-331; pages 211-225)</p> <p>Each territory, including Puerto Rico, may elect to participate in the Exchange and is provided funds for affordability credits if the territory adopts the reforms and requirements for individual and employer responsibility in the bill. (See Sec. 100; page 16 for general authority)</p> <p>Stand alone dental plans will not be able to participate in the Exchange. A provision expressly states that QHBPs may subcontract with stand-alone plans for the provision of dental, vision, mental health, and other benefits. (Sec.100, pages 9 and 11; Sec. 221; page 104)</p>		<p>the fee payments for providers.</p> <p>Consumers, including dental patients, deserve insurance protections that ensure health care value and transparency.</p> <ul style="list-style-type: none"> • Plans should not be allowed to limit payment on services not covered by the plan. • Consumers should have uniform coordination of benefits to permit 100 percent payment of a claim. • Consumers should receive timely payment of claims. • Consumers who choose to do so should be able to assign their benefit to their dentist. • Insurance terms should be written in plain language. <p>Regarding stand alone dental plans – the ADA worked with Senator Stabenow (D-MI) who successfully amended the Senate Finance Committee’s version of health care reform legislation to permit stand-alone dental plans into the Exchange, which also ensures ERISA-regulated consumer protections apply to the stand-alone dental plans. The ADA is continuing to lobby for a similar provision in H.R. 3962, including consumer protections that would not allow dental plans to limit payment on services not covered by the plan.</p>

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Antitrust Issues	A provision restores application of federal antitrust laws to health sector insurers (the business of health insurance and business of medical malpractice insurance) regarding price fixing, market allocation or monopolization (or attempting to monopolize). This provision does not apply to activities concerning loss data, performing actuarial services if doing so does not involve restraint of trade, and information gathering by regulatory entities. (Sec. 262; pages 150-153; see also Sec. 260, page 149 regarding FTC authority)		<p>The ADA is on record supporting the provision in H.R. 3962, which essentially repeals the McCarran-Ferguson Act.</p> <p>The ADA has actively lobbied in support of an amendment of the health care reform legislation to repeal the McCarran-Ferguson federal antitrust exemption for the “business of insurance” because it would boost competition in the health care marketplace.</p> <p>The ADA is also on record supporting several pieces of legislation that would repeal the McCarran-Ferguson federal antitrust exemption for the health insurance industry, including “The Insurance Industry Competition Act of 2009” (H.R. 1583) and the “Health Insurance Industry Antitrust Enforcement Act of 2009” (H.R. 3596), as well as their companion bills in the Senate.</p>
Benefit Packages Offered in Exchange	All Qualified Health Benefits Plans (QHBP) must provide an essential health benefits package that includes preventive services recommended by the United States Preventive Services Task Force. The QHBP essential health benefits package must also include <u>oral health for children</u> younger than 21 years of age. The scope of the oral health benefits will be defined by the Health Benefits Advisory Committee, which is a public-private advisory body (which must include dental experts) that will make recommendations on changes to the essential benefits package and cost sharing levels. There will be no cost-		<p>The ADA supports no cost sharing for preventive services and ensuring oral health expertise on the advisory committee.</p> <p>This provision is consistent with Res. 60H passed by the ADA’s 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that will increase opportunities for individuals to obtain health insurance coverage in all U.S. jurisdictions.</p>

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	<p>sharing for preventive services and there are limits on annual cost-sharing based on level of income. (Sec. 222-223; pages 104-116)</p> <p>In addition, premium-plus plans within the Exchange program may offer adult oral health coverage. (Sec. 303; page169)</p> <p>There is a requirement that no later than one year after enactment, the Secretary shall submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults as part of the essential benefits package. (Sec. 222; page 111)</p>		<p>In an attempt to develop data that might help the ADA lobby for adult dental Medicaid coverage, the Association has proposed the following additional language be included in section 222 study: “Not later than 1 year after the date of enactment of this Act, the Secretary shall also submit to Congress a report containing the results of a study determining the need and cost of providing accessible and affordable oral health care to adults in the Medicaid program at a level necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.”</p>
Individual Mandate and Tax Credits	<p>Individuals are required to have health insurance or pay a fee equal to 2.5 percent of their adjusted gross income or the average premium on the Exchange (whichever is lower). Exceptions are granted for financial hardship, dependents and religious objections. Individuals below the income tax filing threshold are exempt. (Sec. 501;</p>		

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	<p>pages 296-308)</p> <p>Tax credits are provided to those with family income below 400% of the federal poverty level (about \$43,000 for the individual and \$88,000 for a family of four) and the credit will be set on a sliding scale so that the premium contributions are limited to a certain percentage of the individual's income. These credits are available only to those whose employers do not offer coverage or whose share of employer-sponsored coverage costs more than 12 percent of their family income. (Sec. 341-347; pages 225-267)</p>		<p>This provision is consistent with ADA policy (Res. 60H) passed by the ADA's 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that provides incentives for individuals to obtain health insurance coverage.</p>
Employer Responsibility (Small Business Exception)	<p>Employers are required to "play or pay" by either: (1) offering coverage and contributing not less than 72.5% of the lowest cost QHBP (65% for family coverage), or (2) paying a fee of 8% of payroll into a fund. A study will be conducted to examine the impact of this provision and whether a hardship exemption is warranted. (Sec. 411-416; pages 268-280)</p> <p><i>Small business exemption –</i> Small businesses (less than \$500,000 annual payroll) will not have to contribute to their employees' coverage and provides a graduated penalty for firms with payrolls between \$500,000 and \$750,000. (Sec. 512; pages 312-317)</p>		<p>This provision is helpful – but inadequate – to meet the intent of ADA policy (Res. 60H) passed by the ADA's 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that exempts small business employers from any mandate to provide health coverage. The ADA supports the Senate HELP Committee's health care reform proposal to exempt employers with 25 or fewer employees.</p>
Premium Subsidies to Small Businesses	<p>Small businesses (fewer than 25 employees and average wages of less than \$40,000) will be eligible for a tax</p>		<p>This provision is consistent with the intent of Res. 60H passed by the ADA's 2009 House of Delegates that</p>

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	credit on a sliding scale. The full credit (50 percent of the premium cost) is available to employers with 10 or fewer employees and average wages of \$20,000 or less. (Sec. 521; pages 317-325)		states the ADA shall advocate for any health care reform proposal that includes incentives for employers to provide health insurance coverage. The ADA strongly disagrees with phasing out the credit based on average employee compensation. That threshold is a blunt instrument that discriminates against small employers who must offer competitive wages in expensive markets, as well as businesses that employ a number of low income workers as well as higher earners and, on average, exceed the rather low limit in the bill. The ADA recommends eliminating the average wages threshold phase out amount.
Medicaid and CHIP	<p>Medicaid is expanded to all individuals with incomes up to 150 percent of the federal poverty level (\$33,100 per year for a family of four); however, this does NOT include a <i>requirement</i> for dental services for adults. Adult dental remains a state option even though this provision expands Medicaid coverage to children and adults up to 150 percent of the FPL. (Sec. 1701; pages 1012-1021)</p> <p>“Maintenance of effort” (MOE) provision requires states to continue coverage for those populations enrolled as of June 16, 2009 and includes childless adults. However, the ADA understands that this MOE provision is being interpreted as applying to eligibility only and does not obligate a state to continue benefits not required by federal law (such as the EPSDT program). As such, adult dental coverage remains a state option. (Sec. 1703; pages 1027-1034)</p> <p>Medicaid payment rates for primary care practitioners</p>		<p>Concerning Medicaid, none of the current health care reform proposals provide any additional funding for dental Medicaid programs.</p> <ul style="list-style-type: none"> • We think it would be a tragic mistake if Congress passed health care reform but did nothing to improve the plight on those millions of low-income Americans who qualify for dental care under Medicaid but who can't access care due to severe underfunding of the program. • H. R. 3962 increases reimbursement for primary care physicians in Medicaid, but that provision does not include dentists. Since dentists are primary care providers, we should be included in that provision. • Another solution would be to include the Essential Oral Health Care Act (H.R. 2220) in health care reform. That measure provides states with enhanced federal matching funds

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	<p>(does NOT include dentists) for providing primary care services will be paid at 80% of the Medicare rate for 2010, 90% for 2011 and 100% of the Medicare rate in 2012 and in subsequent years. (Sec. 1721; pages 1055-1058)</p> <p>CHIP-eligible children will be required to obtain coverage through the Exchange or Medicaid in 2014.</p> <p>No later than January 1, 2011, the Secretary will be required to develop a set of Medicaid quality measures for maternity care and adult health services. (Sec. 1730; pages 1069-1075)</p> <p>A state will not be considered to have met its obligation under the Medicaid statute (including a requirement to pay providers at a rate sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area) unless the state annually submits to the Secretary a plan providing specific payment rates and data that allows evaluation of the state's compliance. If rejected by the Secretary, the state is required to immediately submit a revised plan. (Sec. 1728; pages 1066-1067)</p> <p>Each year, states must submit a report to the Centers for Medicare and Medicaid Services (CMS) containing information on the determination of Medicaid rates paid to providers. There must be an explanation of the payment methodology and justification for the rates, as well as an explanation of the process that allows</p>		<p>if they choose to redesign their plans to pay dentists market rates, eliminate administrative barriers, educate caregivers and sign up enough dentists to provide care.</p> <p>Concerning CHIP, it is important that the special needs of this population are properly met when transitioning to other plans.</p> <p>The ADA is aggressively seeking an amendment to accomplish the above goal. In addition, the ADA is also seeking to ensure comprehensive dental services are available to the adult Medicaid population.</p> <p>Regarding section 1728 -- Recognizing that it takes more than just addressing payment rates to fix a Medicaid program, the ADA is lobbying for a proposal that would require the states to also report on actions taken to address administrative barriers. Specifically, the ADA proposal requests the addition of the following language: "A State plan under this title shall not be considered to meet the requirement of section 1902(a)(30)(A) for a year unless the State also addresses administrative barriers that make it difficult for beneficiaries to access care and for providers to participate in the Medicaid program, including improving eligibility verification, ensuring that any licensed practitioner may participate in a publicly funded plan without also having to participate in any other plan, simplifying claims forms processing, assigning a single plan administrator for the dental program, employing case managers to reduce the number of missed appointments, and educating caregivers (such as parents and guardians) regarding</p>

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	<p>providers an opportunity to review and comment before the state made the rates final. (Sec. 1746; pages 1114-1115)</p> <p>There is also a requirement for a General Accountability Office (GAO) study regarding federal payments made to Medicaid programs. (Sec. 1747; pages 1115-1117)</p>		<p>the need to seek services.”</p> <p>Concerning the provisions that require states to submit reports to the Secretary and CMS -- these reports could give constituent dental societies and the ADA a platform to highlight shortcomings in the dental Medicaid program with policymakers.</p>
Health Care Quality Issues	<p>There is established a Center for Quality Improvement headed by the Director of the Agency for Healthcare Research and Quality (AHRQ) who shall oversee the Center that develops clinical, managerial and health care delivery “best practices”. The AHRQ shall enter into agreements with “qualified entities” to develop quality measures. A “qualified entity” includes a nonprofit institution with technical expertise in the area of health quality measurement. (Sec 2401- 2403; pages 1322-1338)</p> <p>Within the AHRQ, a Center for Comparative Effectiveness Research (Center) will be established to conduct, support, and synthesize research with respect to outcomes, effectiveness and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively be prevented, diagnosed, treated and managed clinically. The new Center for Comparative Effectiveness Research and the new Health Choices Commission are required to consult with the specialty colleges and academies of medicine in determining any official recommendation</p>		<p>The ADA recognizes the importance of developing quality measures that are understandable and acceptable to all stakeholders. As such, the ADA is moving quickly to establish the Dental Quality Alliance and believes the DQA should be the entity looked to for oral health quality measures.</p> <p>The ADA certainly supports research to improve the delivery of health care. However, it must also be recognized that the dental quality measurement activities are in their infancy stage and there is certainly no mechanism that could accurately identify individual providers that deliver high-quality care.</p> <p>The ADA will monitor these provisions and cautions against an expansion of the use of quality measures into the private insurance market in a manner that could mean that insurers are empowered to either develop or choose quality measures and tie those to reimbursement; perhaps disregarding efforts at developing quality measures through broad-based initiatives such as the newly established Dental Quality Alliance, in which the ADA participates.</p>

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	<p>or standards for best practices. (Sec.1401; pages 733-761)</p> <p>The Center for Medicare and Medicaid Innovation (CMI) will be created within the Centers for Medicare and Medicaid Services (CMS). The CMI will test innovative payment and service delivery models to improve the coordination, quality and efficiency of health care services provided to Medicare and Medicaid recipients with the goal of reducing costs and increasing quality. (Sec. 1907; pages 1198-1207)</p>		
Public Health Infra-structure	<p>The Secretary, acting through the Centers for Disease Control and Prevention, shall establish a core public health infrastructure program that awards grants to state, local and tribal departments for the purpose of addressing infrastructure needs. A Public Health Investment Fund is established to provide additional appropriations for Federally Qualified Health Centers (FQHCs), National Health Service Corps (NHSC) loan repayments, the promotion of primary care medicine and dentistry in “health professional needs areas”, and a scholarship program and a lone repayment program run by the Health Resources and Services Administration called the “Frontline Health Providers Loan Repayment Program” to promote primary care and dentistry. (Sec. 2002; pages 1214-1219; Sec. 2211-2214; pages 1224-1240)</p> <p>The NHSC loan repayment program is strengthened by expressly permitting practitioners to participate on a half-time basis (offering an opportunity to also establish a private practice) and by increasing the annual full-time loan repayment amount to \$50,000 (from</p>		<p>Adequate funding of the public health infrastructure is necessary to help break the cycle of oral disease in our country. The ADA supports the establishment of a core public health infrastructure program within the Centers for Disease Control and Prevention and the Public Health Investment fund, which will provide additional appropriations for a number of public health programs.</p> <p>Regarding H.R. 3962 reauthorization of Title VII, the ADA is pleased the legislation established new funding opportunities and a separate section for the dental program. The Title VII sections also for the first time support teaching programs that address the oral health needs of vulnerable populations.</p> <p>In general, the ADA supports the infrastructure provisions in H.R. 3962 and is very pleased to see the improvements in the NHSC loan repayment program and the granting of liability protection to volunteers at health centers.</p>

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	<p>\$35,000). (Sec. 2201; pages 1220-1223)</p> <p>Volunteers at health centers are extended liability protection. (Sec. 2586; pages 1606-1608)</p> <p>The bill amends Title VII and reauthorizes training funds for the general practice, pediatric and public health dental residency programs. It established a separate section for the dental programs apart from primary and public health medicine programs. Dental hygiene training programs were also included in the new dental cluster. Funding is authorized for planning, developing and operating such programs, and financial assistance for students and faculty. The section also for the first time supports teaching programs that address the oral health needs of vulnerable populations. (Sec. 2215-2216; pages 1240-1246)</p> <p>The Secretary shall establish a school-based health clinic program. Preferences for funding will be given to schools with high percentage of medically underserved children. Before a clinic is established there must be evidence of local need and assurances that services will be provided in accordance with state and local laws and that the clinic has a collaborative relationship with other providers in the area. (Sec. 2511; pages 1352-1360)</p>		
Wellness and Prevention	<p>The Secretary shall develop a national strategy (and reports to Congress) designed to improve the nation's health through evidence-based clinical and community-based prevention and wellness activities. (Sec. 3121; pages 1289-1291)</p>		<p>This provision is consistent with Res. 60H passed by the ADA's 2009 House of Delegates that states the ADA shall advocate for any health care reform proposal that develops prevention strategies that encourage individuals to accept responsibility for maintaining their health and which may reduce costs.</p>

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	<p>There is a Task Force on Clinical Prevention Services and a Task Force on Community Preventive Services that will work cooperatively, as well as infrastructure grants for states, local and tribal health departments. (Sec. 3131-1343; pages 1291-1308)</p> <p>A Prevention and Wellness Trust fund is established with initial funding of \$2.4 billion for fiscal year 2011 and increasing to \$3.6 billion by FY 2014, which will allocate grants to help fund research, community-based services, and public health infrastructure. (Sec. 3111; pages 1286-1289)</p> <p>The Secretary, through CDC, will award grants to support community health workers to educate and provide outreach in underserved communities – including addressing behavioral risk factors associated with untreated dental and oral health problems. (Sec. 2530; pages 1422-1430)</p>		<p>The ADA is pleased more emphasis is being put on prevention, which has always been a key component of oral health care in the United States. The ADA supports the establishment of a Prevention and Wellness Trust Fund in the House bill.</p> <p>Dentistry must be represented in preventive services task force. Rather than the ambiguous statement that the task force will be composed of “individuals with appropriate expertise” this provision should expressly require individuals be appointed to the task force with expertise in medicine, dentistry, mental health and other providers of primary preventive or pediatric services.</p> <p>The ADA supports the oral health prevention education provisions in H.R. 3962. The Association’s proposal for a new dental team member, the Community Dental Health Coordinator (CDHC), meets the needs identified in these provisions for a health care professional with the ability to work in the community providing necessary outreach and education.</p>
Workforce Issues	<p>The Secretary shall establish a Public Health Workforce Corps and a Public Health Workforce Scholarship Program for graduate school programs in public health, dental public health programs and others. (Sec. 2231-2235;; pages 1253-1267)</p> <p>There are also Health Resources and Services Administration grant programs. One program provides</p>		<p>The ADA supports increasing the number of dentists in the public health services.</p>

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	<p>grants (fellowships, etc.) for schools and other entities engaged in increasing the number of individuals in the field of public health workforce, including dental. Another program applies to medical residents. There is also funding for coordination of cultural competency and diversity programs, innovations in interdisciplinary care training. (Sec. 2241-2252; pages 1268-1275)</p> <p>The Secretary shall establish the Advisory Committee on Health Workforce Evaluation and Assessment to make recommendations to the Secretary and Congress on the adequacy of the nation's health workforce. The Advisory Committee shall collaborate with a number of named advisory groups (including health professions organizations) and federal agencies. (Sec. 2261-2281; pages 1275-1286)</p>		
Health Information Technology; Electronic Health Records	<p>Within two years of enactment of the legislation, the Secretary will be required to adopt comprehensive standards to allow implementation of financial and administrative transactions, including near real-time adjudication of claims, electronic funds transfers, machine-readable health plan beneficiary identification cards, etc. (Sec. 115; pages 76-89)</p> <p>The Secretary shall conduct a study of potential methods to increase the use of electronic health records by small health care providers. The study shall consider at least one of the following methods – providing higher reimbursement or other incentives; promoting low-cost electronic health record software packages; training and education; and providing assistance regarding implementation. (Sec. 263; pages 153-154)</p>		<p>ADA policy (Res. 60H) passed by the 2009 House of Delegates states the Association shall advocate for any health care reform proposal that encourage the use of electronic health records with rigorous privacy standards.</p>

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Medical Liability Alternatives (Tort Reform)	The Secretary shall make incentive payments to states with new alternative medical liability laws (only laws enacted after enactment of health care reform qualify). The new law must make the liability system more reliable through prevention or by promoting prompt resolution of disputes. There must also be disclosure of health care errors and maintenance of access to affordable liability insurance. The litigation alternatives consisting of certificate of merit and early offer are acceptable; but there can be no limit on attorneys' fees or caps on damages. (Sec. 2531; pages 1431-1433)		The ADA does not support this provision because meaningful tort reform should include limits on non-economic damages and reasonable limits on attorneys' fees. ADA policy, including Res. 60H passed by the ADA's 2009 House of Delegates, requires the ADA to support medical liability (tort) reform. The ADA supports tort reform legislation that includes but is not limited to mandatory 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 state duties concerning alternative methods of resolving disputes.
Health Savings Accounts, Health Flexible Spending Arrangements	Amounts paid for medicine or drugs will be deductible as a medical expense only if it is prescribed or is insulin. Salary reduction contributions to health flexible spending arrangements through a cafeteria plan will be limited to \$2,500 (indexed for inflation). Currently there is no statutory limit on the amount an employee can contribute. The penalty for nonqualified distributions from health savings accounts (such as distributions that are not used to pay for health care expenses) will be increased from 10 percent to 20 percent. (Sec. 531-533; pages 324-327)		The ADA believes the \$2,500 cap on FSAs should be removed. Res. 60H passed by the ADA's 2009 House of Delegates requires the ADA to support HSAs and FSAs. The ADA has long supported (both in coalitions and independently) the expanded use of health savings accounts and health flexible spending arrangements as an effective means of promoting access to dental services in a manner that maximizes consumer choice of provider. The Association will continue to fight the cap on flexible spending arrangements.
Dental Emergency Responders	The legislation amends the Homeland Security Act to expressly include dentistry as part of the national preparedness system along with colleagues in medicine and public health. (Sec. 2555-2556; pages 1489-1490)		This provision is consistent with ADA policy calling for the Association to advance the role of dentistry in disaster planning and emergency preparedness. It mirrors the "Dental Emergency Responder Act", H.R.

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			903, which the ADA helped develop and has actively lobbied, both individually and in a coalition.
Practitioner Data Banks	The bill eliminates duplication between the Healthcare Integrity and Protection Data Bank (HIPDB) and the National Practitioner Data Bank (NPDB) by sun setting the HIPDB after assuring the information collected by the HIPDB is picked up by the NPDB. (Sec. 1652; pages 1006-1010)		
Indian Health Care Improvement Act	The bill incorporates many provisions of the IHCIA, including the ADA-agreed language that limits the scope of practice for a Dental Health Aide Therapist (DHAT) in Alaska (see pages 1713-1714) and that precludes DHATs from being part of the Community Health Aide Program beyond Alaska (see page 1716). (IHCIA : pages 1635-1990)		ADA supports the provisions noted in the summary of H.R. 3962.
Mandatory Coverage for Children with Congenital or Developmental Deformity, Disease, or Injury	Beginning January 1, 2010, group health plans (both in and outside the Exchange) must provide outpatient and inpatient diagnosis and treatment coverage for a minor child's (21 years of age or younger) congenital or developmental deformity, disease, or injury. (Sec. 108; pages 42-45)		The ADA supports coverage for the diagnosis and treatment of congenital or developmental deformity, disease, or injury because ensuring coverage for cleft lip and palate has been difficult.
Paying for Health Care Reform	There are a variety of relatively small provisions but the primary revenue raiser is a surcharge on adjusted gross income above \$1 million (married filing jointly) and \$500,000 (single), which is estimated to raise over \$460		The ADA opposes the \$2,500 cap on FSAs and the excise tax placed on medical devices. The ADA opposes limits and/or restrictions on Flexible Spending Accounts because they serve as a valuable means of

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	<p>billion over 10 years. (Sec. 551; pages 336-339)</p> <p>The changes in HSAs and FSAs mentioned above are estimated to raise just under \$20 billion over 10 years.</p> <p>There is also an excise tax on the first taxable sale of medical devices (any device intended for humans) equal to 2.5 percent of the price. “First taxable sale” means the first sale for a purpose other than resale after the device has been produced or imported. If a medical device is sold for use in connection with providing any health care service to an individual, such sale shall not be treated as being for the purpose of resale. (Sec. 552; pages 339-344)</p>		<p>using pre-tax dollars to pay for health care services without the bureaucratic hassles generally associated with health benefit plans. A tax on medical devices would add an unnecessary additional expense to the delivery of health care.</p> <p>ADA policy (Res. 60H) passed by the ADA’s 2009 House of Delegates states the ADA shall support a health care reform proposal that is funded in a sustainable, budget neutral manner that does not include a tax on health care delivery.</p> <p>The ADA is pleased to note there are no taxes on health care benefits in H.R. 3962. The ADA opposes a tax on health care benefits or health care services because of the chilling effect on expanding coverage and access to health care services.</p>