

July 22, 2009

Dear Representative:

The American Dental Association (ADA), representing over 157,000 dentists in the United States welcomes this opportunity to comment on the "America's Affordable Health Choices Act of 2009", H.R. 3200, as introduced on July 14, 2009. The Association's comments to specific sections of the bill are addressed below. We hope that you will take these positions into consideration as you work with your colleagues to craft a final bill.

Dentists are also medical care consumers and we understand why policy makers have been focusing their attention foremost on addressing the accessibility and affordability of medical coverage. That being said, acknowledging that the majority of Americans have access to excellent and relatively affordable dental care (in 2007, for example, per capita dental costs were \$316, as opposed to per capita medical costs of \$5,496), we are compelled to point out that too many low-income Americans still suffer needlessly from dental disease. This is unacceptable. Oral health is not elective; it is an integral component of overall health and well being. For too long we have ignored the dire unmet oral health needs of a growing number of Americans unable to access dental care due to economic status, geographic location or a myriad of other barriers. The ADA is adamant that improving access to dental care for those most in need be the focus of any oral health component in a health care reform proposal.

With that in mind, we offer the following recommendations:

Impact on Dental Coverage

It appears that this bill would not apply to dental benefits plans offered separately from medical plans because the definition of an "employment-based health plan" (defined under section 733(a) (1) of ERISA) does not include "limited scope dental benefits" offered separately (p. 9). 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 and oral health for children younger than 21 years of age (p. 28). In addition, premium-plus plans within the Health Insurance Exchange program may offer adult oral health coverage (p. 86). There will be no cost-sharing for preventive services and there are limits on annual cost-sharing based on level of income (p. 28). The Health Benefits Advisory Committee is a public-private advisory body that will make recommendations on changes to the essential benefits package and cost sharing levels.

ADA Comment:

- The ADA recognizes the important role coverage of dental services plays in ensuring good oral health. However, the Association believes the current bill language, which includes oral health coverage for children (or perhaps only preventive services) within the QHBP and offers an opportunity to purchase adult dental coverage only under a more expensive premium-plus plan, could result in a cumbersome, segmented dental delivery system because many families may be forced to purchase two dental plans. One to cover the children (within the Exchange system) and a second outside the Exchange with coverage provided by a dental benefit plan offered separately from a medical plan.

- The ADA is concerned that in giving the United States Preventive Services Task Force (USPSTF) authority to make recommendations on preventive dental services its recommendations will not reflect the current science and evidence supporting preventive interventions specific to oral health without an oral health expert on the task force. **The ADA strongly urges that a dentist be included as a member of the USPSTF** to ensure that recommendations affecting oral health are appropriate.
- The Association is also concerned that the Health Benefits Advisory Committee, which is empowered with the authority to recommend covered benefits as well as the essential benefit package, is not required to include a dentist. Historically, the dental delivery system has been a delivery system distinct from medicine and the treatment of dental disease by dentists and other members of the dental team is a distinct discipline with its own expertise that cannot be fully replicated by physicians or others in the medical field. **The ADA strongly recommends that the legislation expressly provide for the selection of a dentist to serve on the advisory committee.**
- The **Association supports the provision that prohibits cost sharing for preventive services.** Dental professionals have long recognized that preventing dental disease is the most cost-effective way of addressing our oral health challenges.

Special Duties Related to the State Children's Health Insurance Program (CHIP)

A child who is eligible for CHIP will be deemed to be exchange eligible unless the child is Medicaid eligible (p. 102).

ADA Comment: The ADA is concerned that the requirement for CHIP enrollees to obtain coverage through the Health Insurance Exchange may end up not meeting the oral health needs of such children. There should be a mechanism in place to ensure the wrap around benefit is properly administered.

Public Health Insurance Option

The Secretary shall provide for an exchange participating public option plan that will be available throughout the United States and that will be subject to the same requirements imposed on other exchange participating QHBPs. The public option plan is required to offer basic, enhanced and premium plans and may offer premium-plus plans (which could include adult oral health) (p. 117). Initially, the Secretary will establish payment rates for services under the public option plan using the payment rates of parts A and B of Medicare, but with modifications to accommodate services not covered by Medicare (p. 122). After three years, the Secretary could use other "innovative payment mechanisms" such as valued-based purchasing, direct contracting with providers, patient-centered medical home, and others in setting rates (p. 125).

ADA Comment: The **ADA is very concerned with the current version of the public option plan** because it permits the Secretary to *unilaterally* determine payment fees for oral health services within the plan. With regard to oral health services, the Association believes the marketplace is the most efficient means of determining payment rates for health care professionals. This market has worked well in keeping costs down in the current oral health delivery system and should be used by the Secretary in setting payment rates under the public option plan. If a public option plan remains in the legislation, the ADA suggests amending section 223 (a)(3) by adding the following language in bold: "The Secretary shall modify payment rates described in paragraph (2) **using average market billed**

rates in order to accommodate payments for services, such as well-child visits, that are not otherwise covered under Medicare.”

Employer Responsibility

An employer must offer each employee individual and family coverage under a QHBP or a current employment-based health plan and make contributions toward the coverage if coverage is accepted by the employee (p. 143). The minimum employer contribution for individual coverage will be not less than 72.5% of the lowest cost plan that is a QHBP or a current employment-based plan and 65% of the lowest cost plan that is a QHBP or a current employment-based plan for family coverage (p. 146). At some future date, if an employee declines coverage (other than for reasons of already being covered as a spouse or dependent) the employer will be required to contribute to the Health Insurance Exchange Trust Fund (p. 144) at a rate equal to 8% of the average wages paid by the employer during the period of enrollment (p. 149). Employer contributions for part-time employees will be proportional to the hours worked (p. 147).

However, the contribution rate is reduced or in some cases eliminated for small employers (p. 150). Employers with an “annual payroll”, which is defined as the aggregate wages paid by the employer for the preceding year, of less than \$250,000 will not have to pay a contribution. The rate increases by 2% for each incremental increase of \$50,000 in payroll above \$250,000. For example, an employer with a payroll that exceeds \$350,000 but does not exceed \$400,000 will have to pay a contribution of 6%. Employers with payrolls at \$400,000 or above will have to contribute the full 8%.

ADA Comment: The Association believes the payroll amounts should be appropriately indexed to prevent erosion of the small employer provision.

Small Business Employee Health Coverage Credit

A small employer is entitled to a tax credit equal to 50% of the employer’s coverage expenses, which is phased out for employers with 10 to 25 employees and average wages of \$20,000 to \$40,000 per year. The credit is not allowed for highly compensated employees (\$125,000 aggregate compensation).

ADA Comment: 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.

Quality Measurements

The Secretary shall establish and periodically update national priorities for performance improvement with regard to the delivery of health care services. A quality measure is defined as a national consensus standard for measuring the performance and improvement of population health, or of institutional providers of services, physicians, and other health care practitioners in the delivery of health care services (p. 621). The Secretary shall enter into agreements with “qualified entities” to develop quality measures for the delivery of health care services and take into consideration recommendations from the consensus-based qualified entity with a contract with the Secretary, as well as public input (p. 623). Among the many listed assessment goals, the quality measures shall be designed to assess outcomes and functional status of patients (p. 624). A “qualified entity” is a

public, nonprofit or academic institution with technical expertise in the area of health quality measurement (p. 625).

ADA Comment: As a nonprofit institution with expertise in the area of oral health quality measurement, the ADA is participating in the broad-based Dental Quality Alliance (DQA) initiative and supports efforts to develop dental quality measures through that entity. **The ADA seeks clarification on this matter to ensure that initiatives like the DQA meet the criteria for “qualified entities.”**

Medicaid

Individuals in families with incomes below 133% of the Federal poverty level will be eligible for Medicaid (p. 740). This expansion will be fully funded by the federal government.

A state plan must provide services recommended with a grade A or B by the United States Preventive Services Task Force, which shall be covered without cost-sharing (p. 765).

There is also coverage for tobacco cessation outpatient drugs (p. 767).

Payments to primary care practitioners for payment of “primary care services” provided under a state plan will be increased to 80% of the part B Medicare rate for 2010, 90% of the Medicare rate in 2011, and 100% of the Medicare rate in 2012 and subsequent years. This provision would not cover dentists, as “primary care services” are defined in current law as “as physicians’ services which constitute office medical services, emergency department services, home medical services, skilled nursing, intermediate care, and long-term care medical services, or nursing home, boarding home, domiciliary or custodial care medical services.”

ADA Comment: The ADA supports expanding dental Medicaid to cover adults and the “aged, blind and disabled” population. Recognizing that dentists are not included in the definition of primary care practitioners, the Association offers an amendment (see attachment #1) that ensures that individuals covered by a state’s dental Medicaid plan have access to oral health care services to the same extent as such services are available to the population of the state. The amendment targets the fundamental problem with the dental Medicaid program (inadequate funding) by giving a state an option (this is not a mandate) of receiving enhanced federal matching funds if the state chooses to redesign its plan in a manner that: pays dentists market rate fees, eliminates administrative barriers, ensures there are enough dentists signed up willing to provide care, and educates parents and other caregivers on the importance of seeking care to ensure that there is a demand for needed dental services.

Public Health Investment Fund

A Public Health Investment Fund (p. 859) is established to provide additional appropriations (beginning with \$4.7 billion for 2010) for a number of public health programs beyond the amounts appropriated through the normal legislative process.

Among other programs, the fund includes increased funding for:

- Federally Qualified Health Centers;
- National Health Service Corps Scholarship and loan repayment programs;
- the Agency for Healthcare Research and Quality; and
- the “Frontline Health Providers Loan Repayment Program”, run by the Health Resources and Services Administration (HRSA), affecting primary care medicine and dentistry in “health professional needs areas”, which are areas found by the Secretary to have an insufficient

number of practitioners and high needs but are NOT already designated as a health professional shortage areas (p. 870).

ADA Comment: The Association supports this provision.

Training for Dentists and Dental Hygienists

Title VII of the Health Professions Act is provided additional funding for dental residencies, faculty loan repayment, and other activities by allocating \$200 million a year out of the Public Health Investment Fund.

ADA Comment: The ADA is pleased that the legislation establishes new funding opportunities; however, we have concerns about the clustering of general, pediatric and public health dental residency programs with medical residency funding. The ADA believes a separate funding line should be maintained for all dental programs to ensure the dental cluster receives its fair share of funding dollars.

Public Health Workforce

This provision establishes within the Public Health Service the Public Health Workforce Corps, which includes corps officers, civilian employees, and individuals who are not federal employees (p. 898). The Secretary shall use the corps to ensure an adequate supply of public health professionals. The Secretary shall also establish a Public Health Workforce Scholarship Program for graduate school programs in public health, dental public health programs and others.

There is also a provision for a Public Health Workforce Loan Repayment Program and grants for schools and other entities engaged in increasing the number of individuals in the public health workforce. \$50 billion per year from the Public Health Investment Fund will be made available to fund the above projects.

ADA Comment: ADA supports these provisions.

Health Workforce Evaluation and Assessment

The Secretary shall establish the Advisory Committee on Health Workforce Evaluation and Assessment (p. 920) to make recommendations to the Secretary and Congress on the adequacy of the nation's health workforce and related matters. The Advisory Committee shall collaborate with a number of named advisory groups and federal agencies.

ADA Comment: ADA supports these provisions.

Prevention and Wellness

A Prevention and Wellness Trust fund is established with initial funding of \$2.4 billion for 2010 and increasing to \$3.5 billion in 2014, which will allocate funds for prevention task forces, research, community-based services, and public health infrastructure (p. 932). 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.

ADA Comment: ADA supports these provisions.

Public Health Infrastructure

The Secretary, acting through the Centers for Disease Control and Prevention (CDC), will establish a core public health infrastructure program (p. 955) with grants to state, local and tribal health departments. The infrastructure activities will include workforce capacity and competency, health information and analysis, etc.

ADA Comment: ADA supports these provisions.

Finally, the ADA believes H.R. 3200 would be greatly strengthened if the following two provisions were added.

Health Care Coverage Value and Transparency

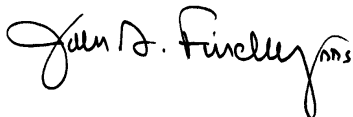
H.R. 3200 provides many needed consumer protections. Unfortunately -- none of these consumer protection provisions apply to dental benefit plans offered separately from medical plans. It is only fair and appropriate that dental patients receive many of the same protections under their dental plans that they will receive under their medical plans. The ADA is proposing an amendment (see attachment #2) that extends several of those protections in a manner that help plan participants, beneficiaries and sponsors to receive the full value of group health plan participation – including those individuals with dental plans offered separately. It should also help ensure transparency between group health plans and participating health care professionals, as well as improved plan efficiency.

Further Insurance Industry Competition

Finally, the ADA believes the bill would be greatly strengthened if it had a provision that addresses antitrust concerns by adopting relevant provisions from the “Insurance Industry Competition Act of 2009,” H.R. 1583. This bill would repeal the McCarran-Ferguson Act’s federal antitrust exemption for the “business of insurance” and the ADA believes that health care consumers and the public generally are adversely affected by the exemption. On July 16, 2009, the Federal Trade Commission (FTC) testified before the Senate Subcommittee on Consumer Protection, Product Safety, and Insurance of the Committee on Commerce, Science & Transportation on the importance of competition to help ensure lower-cost, high quality health care. The ADA believes more can and should be done to boost competition in the health care marketplace and adopting H.R. 1583 will facilitate that effort (see attachment #3).

Thank you, for the opportunity to comment. If further clarification of our suggestions is required, please feel free to contact Mr. Thomas Spangler, Director, Legislative & Regulatory Policy at the ADA’s Washington, DC office at (202) 789-5179 or spangler@ada.org.

Sincerely,



John S. Findley, D.D.S.
President



Kathleen T. O'Loughlin, D.M.D.
Executive Director

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Enclosure

Attachment # 1

Sec. 1726. SUPPORT FOR ENSURING INDIVIDUALS ENROLLED IN MEDICAID HAVE DENTAL SERVICES ACCESS EQUAL TO THE POPULATION OF THE STATE.

(a) In General. Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended by adding at the end the following new subsection:

(aa) Equal Access to Oral Health Care Plan.

(1) INCREASE IN FMAP FOR STATES IMPLEMENTING APPROVED EQUAL ACCESS REQUIREMENTS. In order to ensure adequate provider participation in the plan under this title and to ensure that individuals covered by the plan have access to oral health care services to the same extent as such services are available to the population of the State, subject to paragraph (3), in the case of a State that obtains the Secretary's approval for its plan under this title to incorporate, and to implement, the requirements specified in paragraph (2), notwithstanding section 1905(b), the Federal medical assistance percentage applied under the plan with respect to expenditures for dental and oral health services for individuals covered under the plan shall be increased by 25 percentage points, but not to exceed 90 percent, at the time the approved plan is implemented.

(2) PROVIDER PARTICIPATION AND ACCESS REQUIREMENTS. The requirements specified in this paragraph for a State are that the State provides the Secretary with assurances regarding each of the following:

(A) Individuals covered by the State plan have access to oral health care services to the same extent as such services are available to the population of the State.

(B) Payment for dental services for individuals covered by the State plan is made at levels consistent with market-based rates.

(C) No fewer than 35 percent of the practicing dentists (including a reasonable mix of general dentists, pediatric dentists, and oral and maxillofacial surgeons) in the State participate (whether directly or through a plan providing dental services) under the State plan and there is reasonable distribution of such dentists serving the covered population.

(D) Administrative barriers under this title are addressed to facilitate such provider participation, including improving eligibility verification, ensuring that any licensed dentist 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, and employing case managers to reduce the number of missed appointments.

(E) Demand for services barriers under this title is addressed, such as educating caregivers regarding the need to seek dental services and addressing oral health care literacy issues.

(3) 3-YEAR REVIEW.—Beginning 3 years after the date of the enactment of this section and every 3 years thereafter the Secretary shall evaluate the impact of the increase in the Federal medical assistance percentage under this subsection on the rate of participation of dentists and the use of dental services under the State plan. If the Secretary determines that the increase in such percentage has not resulted in a commensurate increase in such participation and use rate, as determined in consultation with the State involved, paragraph (1) shall no longer apply in such State.

Attachment # 2

At the end the following new division:

DIVISION – HEALTH CARE COVERAGE VALUE AND TRANSPARENCY

SEC. DISCLOSURE REQUIREMENTS.

Section of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1169) is amended by ----

- (1) redesignating subsection (e) as (f); and
- (2) inserting after subsection (d), the following:

(e) Ensure Health Care Coverage Value and Transparency.

- (1) A group health plan, to ensure participants, beneficiaries, and sponsors receive the full value of the plan's coverage, must provide:
 - (i) uniform coordination of benefits to permit 100 percent payment of a claim;
 - (ii) timely payment of claims or pay a penalty for late payment; and
 - (iii) plain language (language that can be readily understood by individuals with limited English proficiency) disclosure of plan terms and conditions, claims payment policies, and cost-sharing and payments with respect to in-network and out-of-network coverage.
- (2) A group health plan, to facilitate transparency and improved plan efficiency is prohibited from applying the plan's fee schedule to services not covered by the plan.

Attachment # 3

Add at the end the following new division:

DIVISION – FURTHER INSURANCE INDUSTRY COMPETITION

SEC. ANTITRUST ENFORCEMENT AUTHORITY

(a) In General.—The Act of March 9, 1945 (59 Stat. 33; 15 U.S.C. 1011 et seq.) (commonly known as the McCarran-Ferguson Act) is amended—

(1) in section 2(b) (15 U.S.C. 1012(b)), by—

(A) inserting “as it relates to unfair methods of competition,” after “Commission Act, as amended,”; and

(B) striking “to the extent that such business is not regulated by State law” and inserting “The Federal Trade Commission Act, as it relates to areas other than unfair methods of competition, shall be applicable to the business of insurance to the extent that such business is not regulated by State law.”; and

(2) by striking section 3 (15 U.S.C. 1013).

(b) Federal Trade Commission Act.—Section 6 of the Federal Trade Commission Act (15 U.S.C. 46) is amended by striking the third undesignated paragraph following subsection (i).

(c) The Department of Justice and the Federal Trade Commission may issue joint statements of their antitrust enforcement policies regarding joint activities in the business of insurance.