

## Health Care Reform Legislation: Side-by-Side Comparison

*This is an August 2009 snapshot of the health care reform debate in Congress.*

Issues	House Tri-Committee Bill <i>America's Affordable Health Choices Act, H.R. 3200</i>	Senate HELP Committee Bill <i>Affordable Health Choices Act</i>	Senate Finance Committee Bill <i>(Bill not introduced)</i>	ADA Comments/ Amendments
<p><b>Creation of an Entity to Regulate the Private Insurance Market and the Government Run Insurance Plan</b></p>	<p>Individuals and employers will be able to purchase “qualified” <u>private</u> coverage (“Qualified Health Benefits Plans”) through a National Health Insurance <b>Exchange</b>. The Exchange will also offer a <u>public</u> insurance plan option.</p> <p>The Exchange serves as a pooling mechanism for offering private coverage (and a public insurance plan) that will be subject to a variety of market regulations, such as prohibition of pre-existing conditions, guarantee issue, premium rating limits, assuring consumer protections, etc. It is also the mechanism used to administer the tax credits and for enforcing the variety of requirements placed on QHBPs.</p> <p>Action taken by the House Energy and Commerce Committee regarding the fees for the <b>public option plan</b> will bring those fees closer to market rates (the government is required to establish a rate using Medicare as the floor and the average qualified health benefit plan rate as the ceiling); however, the ADA strongly believes that more needs to be done to ensure true market rates are used.</p>	<p>State-based American Health Benefit <b>Gateways</b> (no more than one gateway for each distinct geographic area) will offer “qualified” <u>private</u> coverage and a <u>community health insurance option</u>.</p> <p>The Gateway serves fundamentally the same purpose as the Exchange.</p>		<p>The ADA would oppose a <b>government run insurance plan</b> (the public option plan) that:</p> <ul style="list-style-type: none"> <li>• required health care providers to participate,</li> <li>• directly or indirectly dictated fees for the private market,</li> <li>• would lead to a government-run health system, and</li> <li>• did not use market billed rates to determine the fee payments for providers.</li> </ul> <p>Consumers, including dental patients, deserve <b>insurance protections</b> that ensure health care value and transparency.</p> <ul style="list-style-type: none"> <li>• Consumers should have uniform coordination of benefits to permit 100 percent payment of a claim.</li> <li>• Consumers should receive timely payment of claims.</li> <li>• Consumers who choose to do so should be able to assign their benefit to their dentist.</li> <li>• Insurance terms should be written in plain language.</li> <li>• Plans should not be allowed to limit payment on services not covered by the plan.</li> </ul>

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				The ADA is also seeking an amendment to the House bill to ensure consumer protections apply to all health plans, including stand alone dental plans.
<b>Benefit Packages Offered in Exchange or Gateway</b>	<p>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 <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 that will make recommendations on changes to the essential benefits package and cost sharing levels.</p> <p>In addition, premium-plus plans within the Exchange program may offer adult oral health coverage.</p> <p>There will be no cost-sharing for preventive services and there are limits on annual cost-sharing based on level of income.</p>	<p>Gateway qualified plans must also include oral care for children (as yet undefined) as determined by the Medical Advisory Committee. Similar cost sharing provisions to the House bill.</p>		The ADA supports no cost sharing for preventive services and an amendment that would ensure oral health expertise on the advisory committee.
<b>Individual Mandate and Tax Credits</b>	<p>Individuals are required to have health insurance but will be eligible for a credit 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. Those without coverage will be subject to a penalty of 2.5% of modified adjusted gross income up to the cost of the average national premium. Exceptions are granted for financial hardship, dependents and religious objections.</p>	<p>Similar mandate and tax credits with a minimum tax penalty of \$750 per year to enforce the provision. There are also exceptions for those in states without Gateways.</p>		No ADA comment.

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<b>Employer Responsibility (Small Employer Exception)</b>	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.  Small employers (less than \$500,000 annual payroll) will not have to contribute to their employees’ coverage. (This change was adopted by the Energy and Commerce Committee.)	Employers are required to contribute at least 60% of the premium cost or pay \$750 for each full-time uninsured employee (\$375 for part-timers) who is not offered coverage.  Small employers (25 or fewer employees) are exempt from the requirement.		Regarding the House bill, the ADA recommended that the payroll amounts be indexed to prevent erosion of the exception provision over time.
<b>Premium Subsidies to Small Employers</b>	Small employers (fewer than 25 employees and average wages of less than \$40,000) will be eligible for a tax credit on a sliding scale. The full credit (50% of the premium cost) is available to employers with 10 or fewer employees and average wages of \$20,000 or less.	Small employers (fewer than 50 employees with an average wage of less than \$50,000) can get credits (\$1,000 for individual coverage and \$2,000 for family coverage).		Regarding the House bill, 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.
<b>Medicaid and SCHIP</b>	Medicaid is expanded to all individuals with incomes up to 133% of the federal poverty level but this does NOT appear to include dental services for adults.  Medicaid payment rates for primary care practitioners (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.  SCHIP eligible individuals will be required to obtain	Medicaid is expanded to all individuals up to 150% of the FPL but this does NOT appear to include dental services for adults.  SCHIP eligible individuals will be		Concerning <b>SCHIP</b> , it is important that the special needs of this population are properly met when transitioning to private plans.  Concerning <b>Medicaid</b> , none of the current health care reform proposals provide any additional funding for dental Medicaid programs.  <ul style="list-style-type: none"> <li>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</li> </ul>

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	<p>coverage through the Exchange if certain conditions are met.</p> <p>An amendment adopted by the Energy and Commerce Committee would create new measures to pressure states to fund Medicaid properly. States will be required to submit a report annually to the federal government on how they are meeting current Medicaid payment requirements, including whether Medicaid payments are sufficient to enlist enough providers. This report will give constituent dental societies and the ADA a platform to highlight shortcomings in the dental Medicaid program with policymakers. States will be required to include stakeholders (such as state dental societies) in preparing their yearly reports.</p>	<p>given choice of enrolling in SCHIP or a Gateway plan.</p>		<p>qualify for dental care under Medicaid but who can't access care due to severe underfunding of the program.</p> <ul style="list-style-type: none"> <li>• The House bill 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.</li> <li>• 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 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.</li> </ul> <p>The ADA is aggressively seeking an amendment to accomplish the above goal. In addition, the ADA is also seeking to <b>ensure comprehensive dental services are available to the adult Medicaid population.</b></p>
<b>Health Care Quality Issues</b>	<p>There is established a Center for <u>Quality Improvement</u> 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.</p>	<p>The “Interagency Working Group on <u>Health Care Quality</u>” will be convened to coordinate activities among federal agencies; and grants will be awarded for the purpose of developing/expanding quality measures affecting plans and providers. Within 5 years, there will be public reporting of performance measures, including the development of performance websites.</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 <b>Dental Quality Alliance</b> and believes the DQA should be the entity looked to for oral health quality measures.</p>

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	<p>Within the AHRQ, a Center for <u>Comparative Effectiveness</u> 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. However, an amendment in the Energy and Commerce Committee was offered that would require the new Center for Comparative Effectiveness Research and the new Health Choices Commission to consult with the specialty colleges and academies of medicine in determining any official recommendation or standards for best practices.</p>	<p>The “Patient Safety Research Center” is established to help develop best practices using research from a variety of disciplines to identify quality improvements in the delivery of health care.</p> <p>The bill includes a provision that a health plan or insurance issuer must develop reimbursement based on the implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology.</p>		<p>Regarding the HELP provision, 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 is concerned that this HELP provision appears to expand 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>
<b>Public Health Infrastructure</b>	<p>A Public Health Investment Fund is established to provide additional appropriations for FQHCs, 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.</p> <p>A section amends Title VII to provide additional funding for dental residencies, faculty loan repayment, and other activities by allocating \$200 million a year out of the Public Health Investment Fund.</p>	<p>More funding for FQHCs and proposes a change by not requiring FQHCs to be located in medically underserved areas.</p> <p>More funding for the National Health Service Corps (NHSC).</p> <p>There is a similar Title VII provision in the HELP bill.</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>In the House bill, regarding <b>Title VII</b>, the ADA is pleased the legislation established 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.</p>

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				<p>In general, the ADA supported the infrastructure provisions in both bills with this notable exception regarding the location of FQHCs outside medically underserved areas (MUAs):</p> <p>The ADA supports providing FQHCs with increased resources. However, while some flexibility with regard to location might be desirable, ending the requirement for FQHCs to be located in MUAs may be counter-productive. Transportation and other acquisition costs have been shown to be barriers to seeking care for low-income people. This change, if enacted, will work against attempts to increase utilization and undermine the entire reason for designating shortage areas in the first place. The location of FQHCs in an area that is "not needy" could have the practical effect of crowding out low-income people from FQHC services and might facilitate "cherry picking" by the facilities. Allowing FQHCs to operate in another center's catchment area may result in a duplication of facilities. A more logical idea is to expand the original FQHC capacity.</p>
<b>Wellness and Prevention</b>	<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.</p> <p>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 prevention task forces, research, community-based services, and public health infrastructure.</p>	<p>The Preventive Services Task Force shall publish a guide for individuals and organizations on clinical preventive recommendations.</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</p>

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		<p>Oral health prevention education campaign; research based dental caries disease management; school-based sealant program; authority for more oral health infrastructure funding; updating the national oral health surveillance activities are all included in this section.</p>		<p>other providers of primary preventive or pediatric services.</p> <p>The ADA supports the oral health prevention education provision. However, the Association sent the HELP Committee specific questions regarding the way the programs are implemented.</p>
<b>Workforce Issues</b>	<p>The Secretary shall 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.</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 and federal agencies. The Secretary shall also establish the National Center for Health Care Workforce Analysis to evaluate the effectiveness of the federal workforce programs.</p>	<p>A Commission is established to review current and projected healthcare workforce supply and demand and to make recommendations concerning workforce goals. A high priority is oral health care workforce capacity. The Commission will also make recommendations concerning HRSA grants for planning and carrying out state activities for workforce development.</p> <p>The Secretary can award 15 grants for demonstrations of alternative dental providers.</p>		<p>Concerning the HELP bill, the ADA is concerned that the scope of the commission's mandate is too broad for a mere 15 members (most of whom will not be involved in health professions education or practice) to be able to adequately address the workforce goals listed in the legislation.</p> <p>The ADA believes the section concerning alternative dental providers in the HELP bill should be deleted. Deleting this section would reduce the cost of the bill by \$60 million or more over 5 years. Individual states are already assessing and addressing their unique dental access situations and producing a wide variance of solutions. States have worked to develop these new models by finding their own funding sources.</p>
<b>Antitrust Issues</b>	Neither bill addresses antitrust issues.			The McCarran-Ferguson <b>federal antitrust exemption</b>

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				<p>should be repealed.</p> <ul style="list-style-type: none"> <li>• The Insurance Industry Competition Act of 2009 (H.R. 1583), which would repeal the McCarran-Ferguson Act's federal antitrust exemption, would boost competition in the health care marketplace and should be adopted as part of health care reform.</li> <li>• Virtually all policy makers recognize the need to curtail the rising cost of health care coverage and furnish consumers with more coverage options. Repeal of the McCarran-Ferguson exemption would help serve those goals</li> </ul> <p>The ADA is actively seeking an amendment to the HCR legislation to include relevant provisions from the "Insurance Industry Competition Act of 2009", H.R. 1583, which would repeal the McCarran-Ferguson Act's federal antitrust exemption for the "business of insurance."</p>
<b>Paying for Health Care Reform</b>	About half of the costs are financed through savings in Medicare and Medicaid. The remaining costs are financed through a surcharge on families with incomes above \$350,000 and individuals with incomes above \$280,000.	There are no financing provisions in the HELP bill as they fall within the Finance Committee's jurisdiction.		<p>Paying for health care reform must not involve <b>taxes on health care delivery models.</b></p> <ul style="list-style-type: none"> <li>• 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.</li> <li>• The ADA opposes limits on or elimination of Health Savings Accounts because they are proven successful health care coverage alternatives enjoyed by many who value choosing their own providers without restrictions or penalties.</li> </ul>

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				<ul style="list-style-type: none"> <li>The ADA opposes limits and/or restrictions on Flexible Spending Accounts because they serve as a valuable means of using pre-tax dollars to pay for health care services without the bureaucratic hassles generally associated with health benefit plans.</li> </ul>