Insurance Reforms/Definition of Essential Benefits

- Creates state-based exchanges through which individuals can purchase health coverage, with premium and cost-sharing credits available to individuals/families with income between 133-400% of the federal poverty level (FPL). **There is no requirement for health care providers to participate in any of the exchange-based insurance plans. Stand-alone dental plans may operate in the Exchange either separately or in conjunction with a medical plan if the dental plan provides the required children’s oral health coverage.** [Exchange development deadline January 1, 2014]

- Provides for insurance reforms that bar insurers from denying coverage for pre-existing conditions, establishing lifetime or annual limits on coverage or rescinding coverage except in cases of fraud or misrepresentation. Further, group health plans that cover dependent children are required to extend coverage to such dependents until age 26 [Effective beginning 6 months after enactment]

- States that the Secretary of Health and Human Services (HHS) will define the essential health benefits, but the final definition must include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services (including behavioral health treatment), prescription drugs, rehabilitative and habilitative services/devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. HHS ultimately left it to states to choose coverage from the one of the state’s three largest small group plans, the state employee plan, the state’s largest HMO plan, or the Federal Employees Health Benefits (FEHB) Program as the basis for the essential health benefits.

- Requires all qualified health insurance plans, including those offered through the Exchanges and those offered in the individual and small group markets outside the Exchanges, to offer at least the essential health benefits package. [Effective January 1, 2014]

- If the benchmark plan that a state chooses to base their essential health benefits does not include pediatric oral coverage, HHS has determined that states should look to the Federal Employee Dental and Vision Insurance Plan (FEDVIP) or the state’s Children’s Health Insurance Program (CHIP).

Individual Mandate

- All U.S. citizens and legal residents will be required to have ‘qualifying’ health coverage (hardship exemptions made) by 2014. Those that do not comply will face a tax maximum penalty of $95 in 2014, $325 in 2015, and $695 starting in 2016 per adult per year or pay 1.0% of taxable income in 2014, 2.0% in 2015 and 2.5% in 2016, whichever is higher. [Effective January 1, 2014; enforcement delayed until March 21, 2014]

- Provides refundable and advanceable premium credits to individuals and families with incomes between 100-400% FPL to purchase insurance through the health insurance exchanges.

- Provides reduced cost-sharing for individuals and families with incomes between 100-400% FPL enrolled in qualified health plans.

Employer Mandate/Small Business Tax Credit

- Requires employers with more than 50 employees to offer qualified health insurance coverage. Employers that do not offer such coverage and have at least one full-time employee who receives a premium assistance tax credit will be fined $2,000 per total full-time employee. The first 30 employees will not be counted for the penalty calculation. Employers with more than 50 employees that offer coverage, but have at least one full-time employee

Created by the AAOMS Department of Governmental Affairs

Updated February 2014
receiving a premium assistance tax credit, will pay the lesser of $3,000 for each employee receiving a premium assistance credit or $2,000 for each full-time employee. Employers may not have a waiting period for employee enrollment in health coverage that exceeds 90 days. [Originally effective January 1, 2014: delayed until January 1, 2015 for employers with more than 100 employees and until January 1, 2016 for employers with 51-99 employees]

- The law provides for a tax credit for small employers with no more than 25 employees and average annual wages of no more than $50,000 that purchase health insurance for employees and contribute up to 50% of their total premium. [Effective upon enactment]
  - Phase I: For tax years 2010-2013, provides a tax credit of up to 35% of the employer’s contribution toward the employee’s health insurance premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of no more than $25,000. The credit phases-out as firm size and average wage increases.
  - Phase II: For tax years 2014 and later, eligible small businesses that purchase coverage through the state Exchange, can receive a tax credit for two years of up to 50% of the employer’s contribution toward the employee’s health insurance premium. The full credit will be available to employers with 10 or fewer employees and average annual wages of no more than $25,000. The credit phases-out as firm size and average wage increases.

- Requires employers to report the value of the health insurance coverage they provide employees on each employee's annual Form W-2. This reporting is for informational purposes only, to show employees the value of their health care benefits so they can be more informed consumers. The amount reported does not affect tax liability, as the value of the employer contribution to health coverage continues to be excludible from an employee's income, and it is not taxable. [Optional reporting for employers effective January 1, 2011; required reporting for employers effective January 1, 2012]

- Establishes a “Simple Cafeteria Plan” to provide small businesses a safe harbor from the nondiscrimination requirements for cafeteria plans to enable them to better offer tax-free employee benefits. [Effective January 1, 2011]

Medicaid Expansion

- Per the June 2012 Supreme Court ruling, allows states the option to expand of Medicaid to all individuals underage 65 (children, pregnant women, parents, and adults without dependent children) with incomes up to 133% FPL based on modified adjusted gross income. All newly eligible adults will be guaranteed a benchmark benefit package that at least provides the essential health benefits as defined for the exchanges which includes pediatric—but not adult—oral health services although the compulsory standard adult coverage may offer some dental services. [Effective January 1, 2014]

- To finance the coverage for the newly eligible, states will receive 100% federal funding for 2014 through 2016, 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing for 2020 and subsequent years.

Medicare Independent Payment Advisory Board (IPAB)

- Creates an independent, 15-member Medicare Independent Payment Advisory Board (IPAB) tasked with presenting Congress with “comprehensive proposals to reduce excess cost growth and improve quality of care for Medicare beneficiaries.” The Board’s proposals will take effect unless Congress passes an alternative measure that achieves the same level of savings. The Board would be prohibited from making proposals that ration care, raise taxes or Part B premiums, or change Medicare benefit, eligibility, or cost-sharing standards. [Effective upon enactment]
- IPAB proposals to modify payments will be effective for payments years 2015 and beyond.
- This provision provides for the addition of an independent commission with the ability to mandate Medicare payment cuts for physicians, who are already subject to cuts due to the flawed sustainable growth rate (SGR) formula.

**Medicare and Medicaid Claims Submission/Fraud & Abuse**
- The maximum period for submission of Medicare claims is reduced to a maximum of 12 months. [Effective upon enactment]
- Accelerates HHS adoption of uniform standards and operating rules for the electronic transactions that occur between providers and health plans, such as benefit eligibility verification, prior authorization and electronic funds transfer payments. Establishes a process to regularly update the standards and operating rules for electronic transactions and requires health plans to certify compliance or face financial penalties collected by the Treasury Secretary. [Effective upon enactment]
- Initiates several Medicare and Medicaid fraud and abuse prevention initiatives including a new enrollment process for providers and suppliers and a requirement that suppliers and providers implement compliance programs with core elements determined by the Department of Health and Human Services (HHS).

**Quality Measures/PQRI/Payment Reform**
- Extends through 2014 payments under Medicare’s Physician Quality Reporting Initiative (PQRI). Physicians voluntarily participating in PQRI in 2011 will see a 1% increase in incentive payments and a .5% increase from 2012-2014.
- Beginning in 2014, physicians who do not submit measures to PQRI will have their Medicare payments reduced by 1.5%. The penalty will be increased to 2% in subsequent years. [Effective upon enactment]
- Establishes the Center for Medicare and Medicaid Innovation (CMI) within CMS and provides funding for CMI to test innovative Medicare and Medicaid payment and service delivery models that move away from the traditional fee-for-service (volume-based) model to value-based payment models that may include bundled payments, capitated payments, and shared savings payments involving a broader swath of the care continuum. Such initiatives include pilot projects and demonstration programs to create Accountable Care Organizations, an integrated group of providers that will be held accountable for the overall cost and quality of care of traditional fee-for-service Medicare beneficiaries with the cost, risk, and financial rewards shared among all the providers in an ACO. Financial incentives to ACOs would begin in 2012. The impact on oral and maxillofacial surgery is still being assessed, but private insurers are already implementing similar value-based payment initiatives. [Effective upon enactment]

**Imaging**
- Increases the utilization rate assumption for calculating the payment for advanced imaging equipment from 50% to 75% [Effective January 1, 2011]
- Physician must disclose ownership interest in imaging equipment to their patients [Effective upon enactment]

**Prohibition Against Degree of Provider Discrimination**
- Prohibits health insurance issuers from discriminating against providers acting within the scope of practice of their professional licensure and in accordance with state law. [Effective upon enactment]
Excise Tax on Health Plans

- Imposes an excise tax (equal to 40% of the value of the plan that exceeds the threshold amount) on insurers of employer-sponsored health plans with aggregate values that exceed $10,200 for individual coverage and $27,500 for family coverage. The tax is imposed on the issuer of the health insurance policy, which in the case of a self-insured plan is the plan administrator or, in some cases, the employer. [Effective January 1, 2018]
  - The threshold amounts will be increased for retired individuals age 55 and older who are not eligible for Medicare and for employees engaged in high-risk professions by $1,650 for individual coverage and $3,450 for family coverage. The threshold amounts may be adjusted upwards if health care costs increase more than expected prior to implementation of the tax in 2018. The threshold amounts will be increased for firms that may have higher health care costs because of the age or gender of their workers.
  - The aggregate value of the health insurance plan includes reimbursements under a flexible spending account for medical expenses (health FSA) or health reimbursement arrangement (HRA), employer contributions to a health savings account (HSA), and coverage for supplementary health insurance coverage. The aggregate value of the plan will exclude dental and vision coverage. This was a positive alteration from previous language which included dental and vision coverage in the total value of high-cost health plans.

Medical Device Tax

- Imposes on device manufacturers an excise tax of 2.3% on the sale of any taxable medical device. Exempts eyeglasses, contact lenses, hearing aids, and any device of a type that is generally purchased by the public at retail for individual use. [Effective for sales after December 31, 2012]
- While providers are not directly tapped for this tax, it is possible that the increased cost to manufacturers could be passed along to providers through higher prices such taxed devices. This is already being observed.

Medicare Payroll Tax

- Increases the Medicare Part A (hospital insurance) tax rate on wages by 0.9% (from 1.45% to 2.35%) on earnings over $200,000 for individual taxpayers and $250,000 for married couples filing jointly and imposes a 3.8% tax on unearned income for higher-income tax-payers. [Effective January 1, 2013]

Tax Treatment of Consumer-Directed Plans - Flexible Spending Accounts (FSA)/Health Savings Accounts (HSA)

- Limits the amount of contributions to an FSA for health-related expenses to $2,500 per year, indexed for inflation. [Effective January 1, 2013]
- Increases the tax on distributions from a HSA and Archer medical savings amounts (MSAs) (prior to age 65) that are not used for qualified medical expenses to 20% (from 10%) of the disbursed amount. [Effective January 1, 2011]
- Removes over-the-counter medications from list of deductible items from health reimbursement arrangements (HRA), FSAs, and HSAs. The change does not affect insulin, even if purchased without a prescription, or other health care expenses such as medical devices, eye glasses, contact lenses, co-pays and deductibles. [Effective January 1, 2011]
• HSA/FSA accounts are used by patients for dental care, which is not always included in employer-provided insurance. These limitations may have a negative effect on access to dental care for patients without dental coverage.
• Increases the itemized deduction threshold for unreimbursed medical expenses from 7.5% of adjusted gross income to 10% [Effective January 1, 2013]

1099 Tax Form Requirement
• Requires all businesses and nonprofits to file a 1099 tax form for any vendor to which they pay more than $600 annually in goods and services. While previous tax law only applied to unincorporated businesses that purchased more than $600 annually in services, the new law is designed to capture more unreported tax revenue. [Effective January 1, 2012] [This provision was repealed April 14, 2011 via H.R. 4 which passed the House and Senate, was signed by the president and became Public Law No:112-9]

Alternative Dental Health Care Providers
• Authorizes the Secretary to award grants to establish training programs for alternative dental health care providers to increase access to dental health care services in rural, tribal, and underserved communities. The term ‘alternative dental health care providers’ includes “community dental health coordinators, advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other health professional that the Secretary determines appropriate.” The program must be CODA accredited or within a dental education program in an accredited institution. Each entity must also be in compliance with all applicable state licensing requirements. [Effective upon enactment; demonstration projects shall begin within 2 years after enactment and shall conclude not later than 7 years after enactment. Note: The dental provider community has been successful thus far at preventing this program from being funded.]
• Incorporated the Indian Health Care Improvement Act (IHCIA), which includes ADA-agreed language that limits the scope of practice of a Dental Health Aide Therapist (DHAT) and precludes DHATs from being part of the Community Health Aide Program (CHA) beyond Alaska if the program is nationalized; however, it also contains a provision to allow tribes in states that license dental therapists to establish a DHAT program.
• These provisions could promote midlevel dental providers to perform surgical dental procedures and expand the availability of the Alaska DHAT model to other tribal areas of the country.

Study on Healthcare Workforce
• Establishes a National Health Care Workforce Commission to analyze data on the current health professional workforce which includes “oral health care workforce capacity at all levels”, project future worker demand, determine education and training capacity and infrastructure, and evaluate implications of new and existing federal policies that impact the health care workforce; establishes a state grant program to conduct similar strategies. [Effective upon enactment]