ADA American Dental Association

America's leading advocate for oral health

Health Care Reform Legislation: Side-by-Side Comparison

March 23, 2010

Issues	"Patient Protection and Affordable Care Act" Senate-Passed Version – December 24, 2009 (amended in the nature of a substitute to H.R. 3590)	''Health Care and Education Affordability Reconciliation Act of 2010'' H.R. 4872	ADA Comments/ Amendments
Creation of an Entity to Regulate the Private Insurance Market; the Government Run Insurance Plan; Consumer Protections; Impact on Stand Alone Dental Plans	Individuals and small employers (not more than 100 employees) will be able to purchase qualified health plans (QHPs) through a *state* run American Health Benefit Exchange by January 1, 2014, except in plan years before 2016 a state may limit access to the Exchange to employers with no more than 50 employees. Large employers may be allowed into the Exchange beginning in 2017. (page 160) The Exchange must also provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to help small employers to enroll their employees in QHPs. An Exchange may operate in more than one state with approval from affected states and the Secretary and a state may establish subsidiary Exchanges within the state to serve geographically distinct areas, for example. (Sec.1304; pages 126-130 and Sec.1311; pages 130-154)	<u>The reconciliation bill amends the Senate bill (H.R. 3590)</u>	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.
	Immediate market reforms and consumer protections for health plans and issuers in the group and individual markets include no lifetime or unreasonable annual limits, prohibition on rescissions (except for fraud or misrepresentation), extension of dependent coverage to age 26, required coverage and no cost sharing for certain preventive services (e.g. evidence-based and	Extends the prohibition of lifetime limits, prohibition on rescissions, limitations on excessive waiting periods, and a requirement to provide coverage for non-dependent children up to age 26 to all existing health insurance plans starting six months after enactment. For group health	

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	immunizations), an appeals process, uniform explanation of coverage documents and standardization of definitions, required premium refunds if non-claims costs exceed 20 percent (group market) or 25 percent (individual market), unless a state determines a lower rate by regulation. (Sec. 2711-2719(except 2717); pages 18-37) Effective 2014, additional market reforms include prohibition of pre-existing conditions, fair health insurance premiums and comprehensive coverage, guarantee issue and renewability, premium rating limits, non-discrimination based on health status, non-discrimination of providers, and prohibition on excessive waiting periods. There is also a right of the individual to maintain existing coverage. (Sec. 2701-2708; pages 80-99 and Sec. 1251, pages 99-101) Unless a state passes a law to opt out – the Secretary shall offer through the Exchanges in the states a "Community Health Insurance Option" created to compete with other plans. In selecting an entity to offer such an option within a state, the Secretary must determine the entity meets the criteria under the Social Security Act to be eligible to be a Medicare administrative contractor, that it is a nonprofit entity for purposes of offering the option, and that it meets applicable solvency, eligibility, quality control and fraud control standards. The Secretary will negotiate rates for the reimbursement of health care providers under the community health insurance option, which cannot be higher in aggregate than the average reimbursement rates paid by health insurance issuers offering plans in the Exchange. Unless required (and paid for) by a state,	plans, prohibits pre-existing condition exclusions in 2014, restricts annual limits beginning six months after enactment, and prohibits them starting in 2014. For coverage of non-dependent children prior to 2014, the requirement on group health plans is limited to those adult children without an employer offer of coverage.	Consumers, including dental patients, deserve **insurance protections** that ensure health care value and transparency. • **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. The ADA stated it would oppose a **government run insurance plan** (which ultimately was not included in the Senate bill) that: • required health care providers to participate, • directly or indirectly dictated fees for the private market, • would lead to a government-run health system, and

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	this option shall provide coverage only for essential health benefits and nothing shall prohibit a provider from accepting an out-of-pocket payment for a service not included as an essential health benefit. Providers will not be required to participate in a community health insurance option, nor can they be penalized for not participating. (Sec. 1323; pages 183-201) **Stand-alone dental plans** are permitted to 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 required of all qualified health plans (QHPs). (Sec. 1302, see pages 108-109; Sec. 1311, see pages 138-139) For the purposes of determining the amount of any monthly premium, the portion allocable to stand-alone dental plans shall be treated as a premium payable for a QHP. (Sec. 1401, see pages 243-244) The provision in the bill that allows for reduced cost sharing for individuals enrolled in QHPs applies to those who sign up for a QHP and a stand-alone dental plan. (Sec. 1402, see page 263) Each territory, **including Puerto Rico**, will receive an increase in Medicaid payments beginning with fiscal year 2011and enhanced federal matching funds for mandatory expanded enrollment of adults. (Sec. 2005; pages 425-431) States may receive grants to provide consumer assistance and insurance ombudsman programs. (Sec. 2793; pages 37-40) The Secretary, in conjunction with the states, shall establish a process for annual reviews of unreasonable increases in insurance premiums. (Sec. 2794; pages 40-44)	Increases federal funding in the Senate bill for Puerto Rico, Virgin Islands, Guam, American Samoa, and the Northern Marianas Islands by $2 billion. Raises the caps on federal Medicaid funding for each of the territories. Allows each territory to elect to operate a Health Benefits Exchange.	• did not use market billed rates to determine the fee payments for providers. Regarding **stand alone dental plans** – the ADA worked to permit stand-alone dental plans into the Exchange and to subject the plans to the above listed consumer protections, including prohibiting the plans from limiting non-covered services. However, those protections were not included in the legislation.

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	Within 90 days of enactment, the Secretary will establish a temporary high risk health insurance pool program, which will provide grants to states to provide immediate access to coverage for individuals with a pre-existing condition. This program will end on January 1, 2014. (Sec. 1101; pages 45-52) The Secretary shall also establish a temporary reinsurance program for early retirees, which provides a portion of the cost of coverage by participating employment-based plans. (Sec. 1102; pages 52-58) Not later than July 1, 2010, the Secretary, in consultation with the states, will develop a mechanism (including an internet website) that allows consumers to identify affordable health insurance coverage within the state. (Sec. 1103; pages 58-60) Participation by qualified individuals in the Exchange is voluntary. An individual may enroll in any plan – in or outside the Exchange – but all insurance issuers in the individual or small group market must ensure coverage includes the "essential health benefits package", which includes oral care for children. Plans offered by the federal government to Members of Congress and staff must be offered through the Exchange or through a health plan created under this Act. (Sec. 1312; pages 154-161 and Sec. 1302; page105) There is a Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of nonprofit health insurance issuers to compete with the other plans. (Sec. 1322, pages 169-183) For low-income individuals who are not eligible for Medicaid (with household income from 134 percent to		

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	200 of the federal poverty level), states are given flexibility to offer "standard health plans" tailored to the needs of such populations instead of offering coverage through the Exchange. (Sec. 1331, pages 201-212) Not later than July 1, 2013, two or more states may enter into an agreement to permit the offering of qualified health plans in the individual market across state lines. Also, an insurance issuer may offer a nationwide qualified health plan for individuals or the small group market, except in states that opt-out. (Sec. 1333; pages 219- 226)		
Antitrust Issues	No antitrust provision in the Senate bill.	No provision.	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. 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.

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Benefit Packages Offered in Exchange	All Qualified Health Plans (QHPs) must provide an essential health benefits package as defined by the Secretary – but which shall include **pediatric oral care**, limits cost-sharing and has a specified actuarial value. There are bronze, silver, gold, and platinum plans that can be offered and for certain individuals under age 30 – a catastrophic plan can be offered. Contributions to a Health Savings Account (HSA) may be taken into account in determining the level of coverage offered by an employer. The Senate bill allows the continued offering of catastrophic plans that provide coverage for the "essential health benefits" required by the legislation (plus at least three primary care visits) but these plans will be available only for individuals who have not attained the age of 30 or who are exempt from having to purchase coverage because they do not have access to affordable coverage or because of financial hardship. The catastrophic plans can only be offered in the individual market. (Sec. 1302, pages 104-118) The Medicaid and CHIP Payment and Access Commission (MACPAC) will assess policies affecting **Medicaid beneficiaries**, including **payments to providers**. (Sec. 2801; see page 548)	No provisions.	The ADA supports no cost sharing for preventive services and ensuring oral health expertise on the advisory committee. 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.
Individual Mandate and Tax Credits	Beginning in 2014, requires individual to maintain minimum essential coverage or be subject to a penalty of $95 in 2014, $495 in 2015, $750 in 2016 and indexed thereafter. Exceptions are granted for religious objectors, those who cannot afford coverage and others. (Sec. 1501, pages 317-337)	Same as the Senate bill, except: Lowers the flat dollar assessments or penalties to $325 in 2015, and $695 in 2016. Raises the percent of income assessment that individuals pay if they	The tax credit 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

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	Tax credits are provided to those with families with taxable income between 100-400 percent of the FPL, calculated on a sliding scale. Credits are available only to those employees whose employers do not offer coverage; however, an employee may enroll in the Exchange and receive credits where the employer provides less than 60 of the cost of the premium or the premium exceeds 9.8 percent of the employee's income. (Sec. 1401, pages 237-258)	choose not to become insured. The tax credits are increased for families with incomes below $55,000. Assistance is the same for families with incomes from $77,000 to $88,000.	obtain health insurance coverage.
Employer Responsibility (Small Business Exception)	Employers who do *not* offer coverage and have more than 50 full-time employees must make a payment of $750 per full-time employee if the employer has at least one employee receiving the premium assistance tax credit. Employers who do offer coverage and have more than 50 full-time employees but has at least one full-time employee receiving the premium tax credit will pay the lesser of $3,000 for each of the employees receiving a credit or $750 for each full-time employee. Employers with more than 200 employees who offer coverage are required to automatically enroll new full-time employees and continue the enrollment of current employees, although the employee has a right to opt out. (Sec. 1511-1515, pages 342-359)	Consistent with the Senate bill, businesses with fewer than 50 employees are exempt from any responsibility. The assessments on larger businesses that do not offer coverage is lowered to $2,000 per employee and the first 30 employees are excluded from the assessment.	ADA policy (Res. 60H) passed by the ADA's 2009 House of Delegates states the ADA shall advocate for any health care reform proposal that exempts small business employers from any mandate to provide health coverage.
Premium Subsidies to Small Businesses	Small businesses (fewer than 25 employees and average annual wages of less than $50,000) will be eligible for a tax 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	Same as the Senate bill, except the credit will apply to businesses with average annual wages of less than $40,000.	The ADA disagrees with phasing out the credit based on average employee compensation; however, this provision is consistent with the intent of Res. 60H passed by the ADA's 2009 House of

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	less (multiplied by a cost-of-living adjustment for years after 2013). (Sec. 1421, pages 305-317)		Delegates that states the ADA shall advocate for any health care reform proposal that includes incentives for employers to provide health insurance coverage.
Medicaid and CHIP	Beginning in 2014, Medicaid is expanded to all individuals with incomes up to 133 percent of the FPL. There is no requirement for comprehensive adult dental services, although the benchmark coverage that must be provided to adults might offer some dental services. For example, the benchmark plans include the standard BC/BS preferred provider option plan in the FEHBP, the health benefits coverage plan that is offered and generally available to state employees, a health maintenance organization with the largest insured commercial, non-Medicaid enrollment of covered lives in the state involved. (Sec. 2001, pages 392-422) Any clinical preventive services assigned a grade A or B by the United States Preventive Services Task Force will be included for Medicaid-eligible adults. (Sec. 4106; page 1169) There is enhanced federal funding for the CHIP program and Medicaid/CHIP enrollment simplification. (Sec. 2101, pages 432-440 and Sec. 2201; pages 440-446) A state may award grants to providers who treat a high percentage (as determined by the state) of medically underserved populations or other special populations.	Same as Senate bill, except the reconciliation bill provides 100% federal support for all states for newly eligible individuals from 2014-2016, 95% support for 2017, 94% in 2018, 93% in 2019, and 90% support for 2020 and subsequent years. In addition, states that currently extend Medicaid coverage to non-pregnant childless adults will receive addition funds to reduce the states' share of the cost of providing Medicaid coverage to these adults by 50% in 2014, 60% in 2015, 70% in 2016, 80% in 2017, and 90% in 2018. In 2019 and thereafter all states will bear the same state share of the costs of covering non-pregnant childless adults (e.g. 7% in 2019 and 10% thereafter).	Concerning **Medicaid**, none of the current health care reform proposals provide any additional funding for dental Medicaid programs. • We think it would be a tragic mistake if Congress passed health care reform but did nothing to improve the plight of 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. 4872 increases reimbursement for primary care physicians in Medicaid, but that provision does not include dentists. The ADA aggressively lobbied for an amendment to increase Medicaid dental funding and to ensure comprehensive dental services are available to the adult Medicaid population. This supports an

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	(Sec. 5606; pages 2343-2344) The Secretary shall conduct a study to examine the feasibility of adjusting the application of the Federal Poverty Level (FPL) for different geographic areas so as to reflect the variations in cost-of-living among different areas within the United States. (Sec. 1416; pages 2097-2098) The Medicaid and CHIP Payment and Access Commission (MACPAC) will assess policies affecting **Medicaid beneficiaries**, including **payments to providers**. (Sec. 2801; see page 548)		emphasis on family-centered oral health care, empowering parents to serve as role models for their children.
Health Care Quality Issues	To improve **quality of care**, within two years of enactment, the Secretary shall develop reporting requirements regarding plan coverage and **provider reimbursement structures that are designed to improve outcomes**. (Sec. 2717; pages 30-34) The Secretary shall **develop provider-level outcomes measures** for hospitals, physicians and other providers as determined appropriate by the Secretary. The measures will include the five most prevalent and resource-intensive acute and chronic medical conditions, as well as primary and preventive care. (Sec. 10303; pages 2178-2181) The Secretary shall establish a strategy to improve the delivery of health care services, patient health outcomes and population health and collaborate with state agencies	No provisions.	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. 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.

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	in the development of the national strategy. The President shall convene the Interagency Working Group on Health Care Quality to coordinate actions among federal agencies and to avoid duplication of efforts. The Secretary, in consultation with AHRQ and CMS, shall identify gaps in quality measures for health plans and providers. Grants are authorized to carry out these activities. Multi-stakeholder groups will also be formed. Better data collection and analysis will be required and performance data on quality measures tailored to the needs of clinicians, consumers, policymakers, researchers and others will be available on the internet. (Sec. 3011-3015, pages 682-711) Health care delivery research will be conducted by AHRQ (Sec. 3501, pages 1034-1048) and comparative clinical effectiveness research that evaluates health outcomes will be enhanced. (Sec. 6301, pages 1648-1689) A Center for Medicare and Medicaid Innovation (CMI) is established within the Centers for Medicare and Medicaid Services to test innovative payment and service delivery models. (Sec. 3021, pages 712-728)		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.
Public Health Infrastructure	Appropriations are authorized for fiscal years 2010-2014 for **oral health infrastructure –** the CDC will enter into cooperative agreements with the states, territories and tribes to establish oral health leadership and program guidance, data collection, a multi-dimensional delivery system and to implement science-based programs (e.g. sealants and community water fluoridation). (Sec. 4102, pages 1146-1152)	No provisions.	Adequate funding of the public health infrastructure, which fosters public-private collaboration, 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

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	Payments under the National Health Service Corps loan repayment program and state loan repayment programs intended to provide for the increased availability of health care services in underserved or health professional shortage areas (as determined by the state) **will not be subject to taxation.** (Sec. 10908; page 2400) **Funding for National Health Service Corps loan repayments is increased**. (Sec. 5207, page 1333) The Secretary, through the CDC, shall provide funding for research in the area of public health services and systems. This research will be coordinated with Community Preventive Services Task Force and will examine practices relating to prevention with a focus on the priority areas identified in the National Prevention Strategy or Healthy People 2020 report. (Sec. 4301, pages 1218- 1219) The public health surveillance systems are strengthened (Sec. 2821, pages 1255-1257) and the bill establishes a United States Public Health Sciences Track (Sec. 5315; pages 1372-1385) The Public Health Workforce Loan Repayment Program is established to increase loan repayments for public health professionals. (Sec. 5204, pages 1300-1304) The Allied Health Workforce Recruitment and Retention Program would be amended to provide grants to help eliminate shortages of allied health workers, including **dental hygienists**. (Sec. 5205, pages 1305-1306) Title VII is amended with a provision that provides support and development of dental training programs.		Prevention and the Public Health Investment fund, which will provide additional appropriations for a number of public health programs. Eliminating the taxation of NHSC and state loan repayments and expanding NHSC funding are very significant steps toward addressing the access to care problem as such change will enable the funding of many more positions.

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	There are grants to plan, develop and operate in training programs in the field of general, pediatric, or public health dentistry for dental students, residents, practicing dentists, **dental hygienists, or other approved primary care dental trainees**, which emphasizes training for general, pediatric or public health dentistry. The grants would also provide financial assistance to dental students, residents, practicing dentists, and dental hygiene students who are in such programs and who plan to work in the practice of general, pediatric, public health dentistry or dental hygiene. The grants would also help train those who would teach and provide loan repayment programs for dental faculty. (Sec. 5303, pages 1324-1331) There is a separate provision that seeks to increase teaching capacity, authorizing the Secretary to award grants to teaching health centers for new primary care residency programs. The **ADA** is mentioned as an accrediting entity on page 1458. (Sec. 5508; pages 1457-1472) Grants will be available to establish **school-based health center facilities** that provide comprehensive primary care, including oral health services. The purpose of the centers is to serve schools with a large population of Medicaid and CHIP-eligible children. The clinic must make every reasonable effort to establish and maintain collaborative relationships with health care providers in the catchment area. (Sec. 4101, pages 1135- 1146) Individuals who work at free clinics are extended medical liability protection. (Sec. 10608; pages 2383-2384) More funding is provided for FQHCs and the Secretary		

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	is required to use negotiated rule making to develop a comprehensive methodology and criteria for determining medically underserved populations and health professional shortage areas. (Sec. 5601-5602, pages 1508 - 1514)		
Wellness and Prevention	The bill establishes a National Prevention, Health Promotion and Public Health Council to coordinate a national prevention program, as well as a Preventive Services Task Force to review scientific evidence regarding the effectiveness of various services and to make recommendations. The task force will also coordinate with the Community Preventive Services Task Force run by the Centers for Disease Control and Prevention and the Advisory Committee on Immunization Practices. There will also be an education and outreach campaign on the benefits of prevention and a fund to provide grants. (Sec. 4001-4004 , pages 1114-1135) The CDC, in consultation with professional oral health organizations, shall establish a 5-year national, public education campaign focused on **oral healthcare prevention** and education. The science-based strategies would include community water fluoridation and school-based dental sealants, and grants to demonstrate the effectiveness of research-based dental caries management. (Sec. 4102, pages 1146-1152) There is an initiative to expand the utilization of evidence-based prevention and health promotion in the workplace by tasking CDC with facilitating the establishment of employer-based wellness programs.	No provisions.	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. 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 and the oral health prevention provisions in the Senate bill. 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

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	(Sec. 4303, pages 1252-1255)		expertise in medicine, dentistry, mental health and other providers of primary preventive or pediatric services. The ADA supports the oral health prevention education provisions. 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.
Workforce Issues	A National Health Care Workforce Commission is established to make recommendations regarding workforce, such as determining if the demand for health care workers is being met (including supply and distribution), evaluating training and education activities, revising national loan repayment programs, etc. One of the commission's high priorities is the education and training capacity, projected demands, and integration with the health care delivery system of the **oral health care workforce capacity at all levels**. There is also a grant program to enable states to complete similar strategies. Finally, a National Center for Health Care Workforce Analysis is established to work with professional and educational organizations and state and regional centers for health workforce analysis for the purpose of data collection, analysis and reporting. (Sec. 5101-5103, pages 1255-1292)	No provisions.	The ADA supports increasing the number of dentists in the public health services.

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	An **Alternative Dental Health Care Providers Demonstration Project** is established whereby the Secretary is authorized to award grants to 15 entities to establish demonstration programs to train "alternative dental health providers," including community dental health coordinators (CDHC), advance practice dental hygienists, independent dental hygienists, supervised dental hygienists, primary care physicians, dental therapists, dental health aides, and any other professional the Secretary determines is appropriate. Entities eligible to receive grants include institutions of higher education, community colleges, FQHCs, IHS facilities, a state or county public health clinic, a public-private partnership, or a public hospital or health system. The program must be accredited by the Commission on Dental Accreditation or within a dental education program in an accredited institution. **Each entity receiving a grant under this section shall certify it is in compliance with all applicable state licensing requirements. Nothing shall prohibit a dental health aide training program approved by the IHS from being eligible for a grant.** (Sec. 5304, pages 1331-1334)		The **Alternative Dental Health Care Providers Demonstration Project** provision should be amended to preclude the funding of mid-level dental providers who could perform surgical procedures.
Health Information Technology; Electronic Health Records	**Regarding administrative simplification**, the operating rules for health information transactions to facilitate the electronic exchange of information shall be adopted by the Secretary in order to facilitate determination of an individual's coverage eligibility and financial responsibility, the establishment of transparent claims and denials management processes, and a means to reduce the number and complexity of forms, among other objectives. (Sec. 1104; pages 60-80) (See also,	No provisions.	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.

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	Sec. 10109; pages 2120-2124) Not later than 180 days after enactment, the Secretary shall develop interoperable and secure standards and protocols that facilitate enrollment of individuals in federal and state health and human services programs, which also apply to group health plans and health insurance issuers. (Sec. 3021; pages 368-389)		
Medical Liability Alternatives (Tort Reform)	The Secretary is authorized to award grants to states for the development of alternatives to current tort litigation for resolving disputes over injuries allegedly caused by health care providers or health care organizations. The proposed alternative must allow patients the ability to opt out of or voluntarily withdraw from participating in the alternative at any time and to pursue other alternatives, including litigation. The Secretary shall consult with a review panel, which is established by the Comptroller General and will include representatives of patient advocates, health care providers and organizations, attorneys with expertise in representing patients and providers, medical malpractice insurers, state officials and patient safety experts. Reports shall be sent to Congress annually and the Secretary shall contract with an appropriate research organization to evaluate the program. (Sec. 10607; pages 2369-2383)	No provisions.	The Senate bill does not provide meaningful tort reform, which 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.

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Health Savings Accounts, Health Flexible Spending Arrangements	There would be a $2,500 annual limit on the amount of salary reduction contributions to flexible spending arrangements (FSAs). (Sec. 9005; pages 1959-1960) The penalty for nonqualified distributions from health savings accounts and Archer MSAs (such as distributions that are not used to pay for health care expenses) will be increased from 10 percent to 20 percent. (Sec. 9004; page 1959) Over-the-counter medicine would no longer be eligible for reimbursement under HSAs, FSAs, or HRAs. (Sec. 9003; pages 1957-1959)	Same as Senate bill, except the caps on FSAs are delayed until 2013.	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.
Practitioner Data Banks	The Senate bill eliminates duplication between the HIPDB and the NPDB. (Sec. 6403; pages 1713-1725)	No provisions.	
Indian Health Care Improvement Act	The bill, by reference, includes the IHCIA as reported by the Senate Committee on Indian Affairs in December 2009 (S. 1790). The bill also contains a number of key amendments to the IHCIA. Similar to H.R. 3962, the Senate IHCIA includes the ADA-agreed language that limits the scope of practice of a Dental Health Aide Therapist (DHAT) and contains the general prohibition that precludes DHATs from being part of the Community Health Aide Program (CHAP) beyond Alaska if the program is nationalized by the Secretary. **However, unlike H.R. 3962, the Senate bill contains**	No provisions.	ADA opposed the DHAT provision in the Senate bill.

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	an exception to the general prohibition of DHATs practicing outside of Alaska under the CHAP program. Specifically, DHATs will be permitted in the CHAP program if requested by an Indian tribe or tribal organization located in a state in which the use of DHAT or midlevel provider services is authorized under state law to supply such services in accordance with the state law. There is also a general statement that nothing shall restrict the ability of the Service, an Indian tribe, or tribal organization from participating in any program or to provide any service authorized by any other federal law. The bill also states the Secretary shall not fill any vacancy for a dentist with a DHAT. (Sec. 10221; pages 2173-2176)		
Standards for Accessible Medical Diagnostic Equipment	Not later than 24 months after passage of this Act, the Architectural and Transportation Barriers Compliance Board, in consultation with the FDA, shall promulgate standards setting forth the technical criteria for medical diagnostic equipment, **including equipment used for dental examinations or procedures**. The standards shall ensure the equipment is accessible to, and usable by, individuals with accessibility needs and shall allow independent entry to, and use of, the equipment by the individuals to the maximum extent possible. (Sec. 4203, pages 1198-1199)	No provisions.	The ADA will work to ensure there is a proper balance between cost of implementation, which might affect access to care, and the needs of individuals with special needs.
Waste, Fraud and Abuse Provisions		Authorizes the Centers for Medicare & Medicaid Services (CMS) to work collaboratively with the Internal Revenue Service (IRS) to disclose to CMS those entities that have evaded filing taxes and	

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		matching the data against provider billing data to enable CMS to better detect fraudulent providers billing the Medicare program. Increases funding for the Health Care Fraud and Abuse Control Fund and indexes funds to fight Medicaid fraud based on the increase in the consumer price index.	
Paying for Health Care Reform	The bill places a 40 percent tax levied on insurance companies or plan administrators for any plan above $8,500 for single coverage and $23,000 for family coverage in 2013, increased over time consistent with the cost-of-living adjustment. The tax would apply to the portion of the premium in excess of the threshold. There is a transition rule for states with highest premium costs. All group health policies (e.g. dental, vision, FSAs, HSAs) offered to the same employee would count toward the threshold. (Sec. 9001, pages 1941-1956) The bill would increase the hospital insurance tax (Medicare) by .5 percent for individuals earning over $200,000 or over $250,000 for those who file jointly. (Sec. 9015, pages 2000-2003) There would be a $2,500 annual limit on the amount of salary reduction contributions to flexible spending arrangements (FSAs). (Sec. 9005; pages 1959-1960) An annual fee of $2 billion will be imposed on the companies that manufacture or import medical devices	The high premium excise tax would not go into effect until 2018 and the tax threshold would be increased to $10,200 for single coverage and $27,500 for family coverage. The value of **dental** and vision plans would not be included in making the determination as to whether the plan exceeds the threshold. The Medicare hospital insurance tax is modified to include net investment income, such as interest, dividends, rents, and royalties. The tax on net investment income would apply only for single filers in excess of $200,000 and $250,000 for joint filers. The excise tax on medical device manufacturers is delayed until 2013and converts the industry fee to an excise tax on the first sale for use of medical devices at a rate of 2.9%.	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 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. 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. The ADA opposes the various taxes on health care benefits or health care

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	beginning in 2011, apportioned among the manufacturing sector based on market share. (Sec. 9009, pages 1980-1986 and Sec. 10904; pages 2389-2390) Beginning in 2011, an annual fee of $ 2 billion (increased annually and reaching a level of $10 billion by 2017) will be imposed on entities engaged in the business of providing health insurance, apportioned based on market share. (Sec. 9010; pages 1986-1993 and Sec. 10905; pages 2390-2397) The proposed tax on voluntary "cosmetic surgery and medical procedures" was eliminated in favor of a tax on indoor tanning services. (Sec. 10907; pages 2397-2399) The penalty for nonqualified distributions from health savings accounts and Archer MSAs (such as distributions that are not used to pay for health care expenses) will be increased from 10 percent to 20 percent. (Sec. 9004; page 1959) Over-the-counter medicine would no longer be eligible for reimbursement under HSAs, FSAs, or HRAs. (Sec. 9003; pages1957-1959) A new "Simple Cafeteria Plan" for small businesses is established, which will enable such businesses to be better able to offer tax-free benefits to their employees. (Sec. 9022, pages 2009-2016)	The fee on health insurance providers would be delayed until 2014 and provides exceptions for non-profits that target low-income populations and others.	services in the Senate bill because of the chilling effect on expanding coverage and access to health care services.