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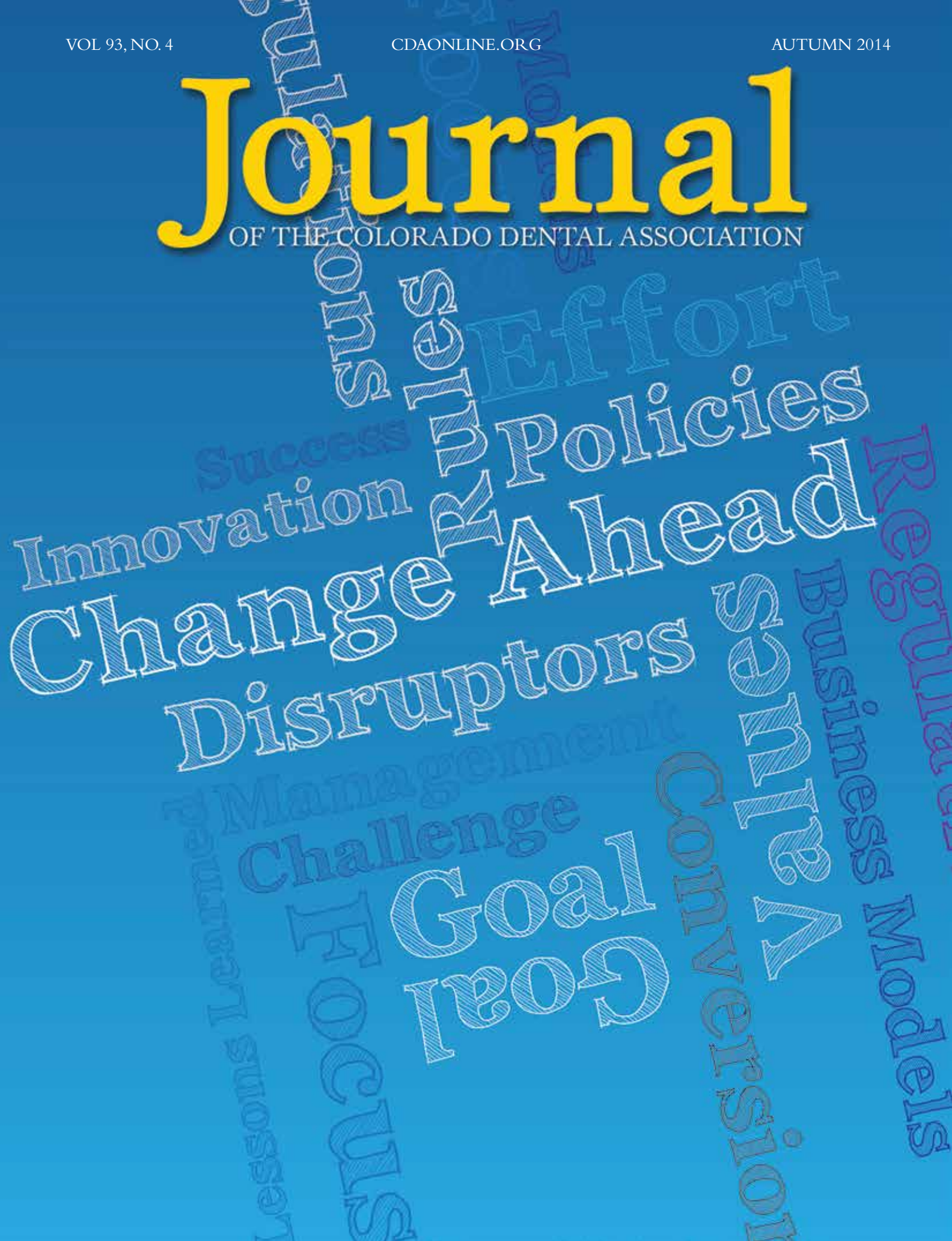

The Affordable Care Act: What it Really Means for You

By Stephen Weatherby, CFP™

President Obama signed the Affordable Care Act (ACA or "Obamacare") on March 23, 2010. Since that day, the confusion has grown and many have differing views on the topic. The law is intended to lower the cost of healthcare and the cost of coverage for all Americans, and provide more rights to insured patients.

There is a lot of information available regarding the effects of the ACA on the healthcare industry as a whole, but what about dentists specifically?

About three million children nationwide are expected to gain some form of dental benefits by 2018 as a result of the ACA. Approximately one-third will gain Medicaid dental coverage, and two-thirds will gain private dental coverage through health insurance exchanges and employer-sponsored plans. Ultimately, this will reduce the number of children who lack dental benefits by approximately 55%.

The State of Colorado has determined that the required pediatric dental plan through Connect For Health Colorado be modeled after the benefits offered by the Child Health Plan Plus (CHP+) program, currently offered to lower-income families. Delta Dental of Colorado helped develop this plan in 2002 and currently administers this program. The state is increasing the out-of-pocket maximums under Connect for Health Colorado to $700 for an individual child or $1,400 for a family with two or more children. This new benefit plan gives children up to age 19 access to oral health services including:

- Diagnostic and preventive care (initial exams, cleanings, fluoride treatment, sealants and x-rays).
- Basic care such as fillings and simple extractions.
- Major services such as crowns.

A fair number of adults across the country will gain some level of dental benefits from the ACA, but only 4.5 million of these adults, about one-third of the total, are expected to gain extensive dental benefits through Medicaid. An additional 800,000 are expected to gain private dental benefits through health insurance exchanges. Assuming the increased population utilizes Medicaid dental services in the same pattern as today's Medicaid beneficiaries, the expansion is estimated to generate an additional 7.5 million adult dental visits.

Accountable Care Organizations (ACO) – groups of doctors, hospitals, and other healthcare providers, who come together voluntarily to give coordinated high quality care to their Medicare patients – could help bridge the gap between oral and general healthcare, improve coordination of dental care and help reduce overall healthcare costs, including oral care. Generally, dental care is not part of the core services provided within existing ACOs – but this might not be the case going forward. Since dental care for children is an essential health benefit under the ACA, there are some immediate opportunities to better coordinate dental and medical care with the pediatric population.

There is strong evidence that reforming Medicaid and increasing reimbursement rates to market levels would increase access to dental care. With that being said, the ACA still does not do enough to address or resolve administrative inefficiencies or low dental provider reimbursement levels seen at the state level.

The Revenue Act of 1978 created Health Care Flexible Spending Accounts (FSAs) as a way for consumers to reduce their out-of-pocket healthcare costs. FSAs are voluntary, employer-sponsored plans that allow employees to devote pre-tax dollars to an account, which they may spend on qualified medical expenses

without incurring taxes. The caveat is that any unused money still in the account at the end of the plan year is forfeited to the employer. The reason for this "use it or lose it" provision is to prevent consumers from using FSAs as tax shelters.

Before the ACA, examples of qualified medical expenses included: co-payments, dental care, hospital fees, prescription drugs, over the counter drugs, psychiatric care, and office visits. Additionally, before the ACA, there was no legal limit on contributions to FSAs; any limits were placed by individual employers. All of this may change. The ACA contains two provisions that potentially limit the attractiveness of FSAs to employees. The first provision eliminates over-the-counter (OTC) drugs from the list of FSA qualified medical expenses unless consumers have prescriptions for them. The second provision caps the amount of money an employee can contribute to an FSA at $2,500.

In contrast, Health Savings Accounts (HSA) are relatively unscathed by healthcare reform. An HSA is a healthcare account that requires the individual to have medical coverage under a high deductible health plan. While an FSA is restricted to employee contributions, an HSA allows contributions to be made by the employer as well. The threat that HSA-qualified health plans could not meet the actuarial value requirements of Obamacare have not materialized. Accordingly, HSAs remain not only viable, but a very effective way of helping employers curtail the growth in the costs of their benefit plans. HSA-qualified health plans generally mean lower premiums, and employers can realize significant tax savings by implementing an HSA program. Employers that provide employees with the tools and education to encourage full participation in the consumer-directed healthcare experience, are realizing the benefits by increasing employee satisfaction while reducing health benefit costs.

What About Taxes?

Dental devices are taxed by the Medical Device Tax, which is an Internal Revenue Code that imposes an excise tax on the sale of certain medical devices by the manufacturer or importer of the device. The Medical Device Tax is anticipated to financially support the ACA. Some have expressed concern of a "trickle-down effect" making its way to the provider and patient as the manufacturers increase prices to offset the tax. Keep in mind that dentists will not be responsible for collecting, reporting, or paying the new 2.3% tax. Also, the tax on "devices" specific to dentistry

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will, in many cases, be applied to the materials from which dental devices are manufactured, rather than to the customized items supplied by a dental laboratory, whether or not a device is ultimately adjusted and adapted by the dentist for a patient. "Device" is used as a term-of-art since many "devices" would be more commonly described as "products," "materials," or "substances." Another thing to note is dentists should be alert in reviewing manufacturer and vendor price lists and invoices to make sure that the 2.3% tax is not being applied as a general cost increase with respect to all items, but is only being applied in cases where the law so requires. It may be prudent to contact your vendor to ask the question.

What about you, as an employer?

The ACA does not require small businesses with 50 or fewer employees to provide health insurance. More than 99% of dental practices fall under this small business classification.

Small business employers who pay at least 50 percent of the premium for employee coverage may qualify for a small business tax credit. To qualify, the employer must have fewer than 25 full-time equivalent employees whose average annual wage does not exceed $50,000 per employee. The tax credits, which disappear after 2016, will be available on a sliding scale to assist the purchase of health insurance.

Obviously, this is just a few of the highlights on how your practice may or may not be affected, but I'm certain that you will notice the effects as we get further engrossed in the new age of healthcare. So, in its inaugural year of implementation, has the ACA affected you? I'm guessing the answer is "yes." If it hasn't yet, it will.

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Resources:

"4 ways the ACA will (and will not) impact dentistry." *Mouthing Off, www.asdablog.com,* Jan. 24, 2014.

"Affordable Care Act strengthens dental Medicaid and pediatric programs." *ASDA News*, August 2012.

"Dental advocacy efforts adapt to a new political reality." *ASDA News,* January 2013

"Accountable Care Organizations Present Key Opportunities for the Dental Profession." April 2013, Marko Vujicic, Ph.D.; Kamyar Nasseh, Ph.D.

Patient Protection and Affordable Care Act (Enrolled Bill [Final as Passed Both House and Senate] - ENR) *[H.R.3590.ENR].*