Oral Health Provisions in the House Passed Health Reform Package

The House of Representatives took the historic step of passing a health reform package on March 21, 2010 which included an unprecedented investment in the oral health of all Americans and children, in particular. The House voted on passage of the Senate health reform bill that passed in December of last year followed by a second vote approving a budget reconciliation bill that included numerous "fixes" to the Senate bill important to House members. Although the oral health provisions were not significantly altered from the original Senate bill, one change included in the budget reconciliation that has not been covered by CDHP previously, and is not listed below, is the exemption of dental benefits subject to the high-cost plan excise tax. Below is a summary of oral health provisions included in final bill, organized under the categories of *Coverage and Access*, *Prevention and Infrastructure* and *Workforce and Training*. For a complete list of oral health provisions, including legislative language from the original Senate bill, *Patient Protection and Affordable Care Act*, see CDHP's Senate Health Reform Toolbox which is available in the in the Health Care Reform Center on CDHP's web site at www.cdhp.org.

Coverage and Access

- **Oral Health Services for Children** – Requires that insurance plans offered under a State Exchange include oral care for children. Bars insurance plans operating under the Exchange from charging out of pocket expenses for preventive services, including preventive pediatric oral health services.

- **Stand-alone Dental Plans** – Allows stand-alone dental plans to participate in the Exchange, with the following specifics:
  - Exempts stand-alone dental plans from offering the full essential benefits package.
  - Allows plans operating under the exchange not to offer oral care for children if there are stand-alone dental plans in the Exchange that do offer it.
  - Allows stand-alone dental plans to participate in the Exchange, as long as they offer a pediatric dental benefit.
  - Allows beneficiaries covered under the Exchange to use their tax subsidy for both a stand-alone plan and a medical plan.
  - Cost-sharing reductions may not be imposed on stand-alone dental plans.

- **MACPAC and payments to dental professionals** – Requires the Medicaid and CHIP Payment and Access Commission (MACPAC) to review and report to Congress on payments to dental professionals.

Coverage and Access (Continued)

- **Dental Coverage in Medicare Advantage** – Requires Medicare Advantage Plans to use rebates to pay for dental coverage, and other services.

- **Medicaid and CHIP Coverage** – Expands Medicaid coverage to 133% of the federal poverty level with an enhanced federal matching rate and extends CHIP until 2019 with additional federal funds. Continues the guarantee of dental coverage passed as part of CHIRPA in 2/09.

- **School-based Health Centers** – Provides grants to school-based health centers and includes oral health services in qualified services to be provided at those centers.

- **Dental Medical Diagnostic Equipment** – Establishes standards for accessibility of medical and dental diagnostic equipment for persons with disabilities.

Prevention and Infrastructure

- **Public Education Campaign** – Requires the Secretary to establish a 5-year, evidence-based public education campaign to promote oral health, including a focus on early childhood caries, prevention, oral health of pregnant women, and oral health of at-risk populations.

- **Dental Caries Disease Management** – Establishes a grant program to demonstrate the effectiveness of research-based dental caries disease management.

- **School-based Dental Sealant Programs** – Requires that all states, territories and Indian tribes receive grants for school-based dental sealant programs. (Note: Currently only 16 states benefit from these grants.)

- **Cooperative Agreements to Improve Oral Health Infrastructure** – Requires the CDC to enter into cooperative agreements with the states, territories and Indian tribes to improve oral health infrastructure through leadership and program guidance, data collection and interpretation of risk, delivery system improvements, and science-based population-level programs.

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Prevention and Infrastructure (Continued)

- **Oral Health Care Surveillance Systems** – Requires that the Secretary update and improve national oral health surveillance by:
    - requiring the inclusion of oral health reporting on pregnant women through PRAMS (Note: currently the oral health component of PRAMS is optional);
    - retaining the current NHANES "tooth-level" surveillance (Note: This reverses plans to drop tooth-level analysis in NHANES and replace it with "person-level" analysis and allows ongoing longitudinal analysis of American's oral health status);
    - requiring the MEPS survey findings be validated through a "look back" procedure (Note: currently MEPS conducts this validation for medical expenditures but not for dental expenditures);
    - requiring all states to participate in the CDC's National Oral Health Surveillance System. (Note: currently only 16 states are required to participate.)

Workforce and Training

- **Alternative Dental Health Care Providers** – Establishes a five-year, $4 million 15-site demonstration program beginning within two years after enactment specifically to "train or employ" alternative dental health care providers. Defines "alternative dental providers" to include currently proposed new dental professionals and others to be determined by the DHHS Secretary. Charges the DHHS Secretary to contract with the Institute of Medicine in evaluating this program.

- **National Health Care Workforce Commission** – Establishes a National Health Care Workforce Commission, for which oral health care workforce capacity is a designated high priority area for review. The Commission will: support national, state and local policymaking; coordinate workforce issues across agencies; evaluate the education and training of health professionals with regard to demand for services; facilitate coordination across levels of government, and encourage workforce innovations.

- **Workforce Development** – Establishes a unique appropriations line-item for training of general, pediatric, and public health dentists and appropriates $30M for FY2010 to train oral health workforce. (Note: currently dental and medical training is appropriated in a single lump sum.) Expands "Title VII" dental workforce training program to include:
    - training of dental students and practicing dentists as well as residents (Note: currently the program supports only the training of dental residents);
    - providing financial assistance to dental trainees (including dental hygienists);
    - developing new training programs
    - expanding faculty capacity through traineeships and fellowships for dentists committed to teaching; grants for faculty development; and faculty loan repayment programs;
    - advancing predoctoral training in primary care dentistry;
    - providing technical assistance to pediatric dental training programs in population and public health issues.

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Workforce and Training (Continued)

- **Faculty Loan Repayment Program** – Establishes a dental faculty loan repayment program for faculty engaged in primary care dentistry to include general dentistry, pediatric dentistry, and public health dentistry. Priorities are established for eight categories of faculty who:
  - collaborate with medical care providers
  - demonstrate retention of trainees in primary care and public health dentistry;
  - demonstrate training of rural, disadvantaged, and minority dentists;
  - collaborate with FQHCs and other safety-net providers;
  - teach in programs that target underserved populations of all ages and medical and social conditions;
  - teach cultural competency and health literacy;
  - succeed in placing graduates in underserved areas or in the service of underserved populations;
  - intend to establish training programs for special needs populations (inclusive of disabled, cognitively impaired, medically complex, physically limited, and vulnerable elderly).

- **Public Health Workforce** – Establishes through the Surgeon General a multidisciplinary health professional training program for select individuals committed to public health and safety. The program supports stipends and loan repayments as well as grants to institutions (including dental schools) and obligates trainees to service in the National Health Service Corps proportional to the years of training support. Requires that Track trainees tailor their predoctoral education and postdoctoral training to disciplines pertinent to public health and safety and that educational preparation involve community-based experiences in multidisciplinary teams. Establishes "Elite Federal Disaster Teams" comprised of Track faculty and students to respond to national emergencies (public health, natural disaster, bioterrorism, and other emergencies).

- **Primary Care Residency Programs** – Establishes three-year, $500,000 grants to establish new primary care residency programs, including dental programs.

- **Graduate Medical Education** – Provides funding for new and expanding graduate medical education, including dental education.

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