FAQs for Arkansas Dentists:
The Impact of the Patient Protection and Affordable Care Act on Health Care and Insurance in Arkansas

The Patient Protection and Affordable Care Act (PPACA), sometimes called “Obamacare,” was legislation passed by the U.S. Congress and signed into law on March 23, 2010. It has far-reaching effects for health care consumers, providers, and the insurance industry. Legislatively, it is likely the most disruptive innovation that the United States has seen since the advent of Medicare and Medicaid via the Social Security Act of 1965. Not unlike when those programs were introduced, PPACA has met with political pushback, legal challenges, and both proponents and opponents in the public and health care industries. This is not uncommon with such sweeping change. In fact, only 26 states opted to adopt Medicaid in 1966, the year after legislation creating the program passed. Similarly, roughly half of states have opted to expand their Medicaid programs through PPACA after the U.S. Supreme Court ruled in June 2012 that it is optional for states to do so.

The scope of PPACA is so broad that it will be years before all of its provisions will be fully implemented and its effects fully understood. Many of the law’s consumer protections related to insurance are already effective. The major provisions involving expanded insurance coverage become effective in 2014, while other provisions become effective later—including some that could affect the existing Children’s Health Insurance Program (CHIP). Importantly, for Arkansas the law and its regulations have brought challenges that the state has attempted to mitigate and opportunities on which the state has capitalized. Many people across the state have been working to proactively shape the future of our health system—undertaking reforms to improve the health payment system, strategically planning for our future health workforce, implementing statewide use of health information technology, and increasing the number of Arkansans with health care coverage.

Although the focus of PPACA is not the dental industry, many provisions in the law will affect dentists, the way that dental care is delivered, and the financing of dental care for consumers. It is imperative that the state prepare for implementation of PPACA and that dentists better understand the implications of the law on health care and insurance; Arkansas’s approach to the law; and its effects on dentists as members of the health care workforce, consumers, and employers. The following frequently asked questions (FAQs) are designed to provide you with this information.

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General Provisions of PPACA

1. **What do the major provisions the Patient Protection and Affordable Care Act (PPACA) intend to accomplish?**

PPACA (and the law that amended it, the Health Care Education and Reconciliation Act of 2010) has goals to increase access to affordable insurance coverage, keep future health care costs under control, and improve the quality of care. The federal health care law can be condensed into five major areas of emphasis.

- **Guaranteed issue:** This requires that insurers offer policies without regard to any pre-existing medical condition, and partial community rating requires insurers to offer the same premium to all applicants of the same age and geographical location without regard to gender or pre-existing conditions. For more information about elimination of pre-existing condition exclusions go to question 2. For a discussion of community rating go to question 3.

- **Individual responsibility:** Often called the “individual mandate,” this requires most Americans to obtain insurance coverage or pay a penalty. For more information about who is required to purchase coverage go to question 4, and for more information about the penalty go to question 5.

- **Health Insurance Marketplace (HIM):** Formerly called the “health benefits exchange,” this is a virtual insurance megamall that will operate in each state, offering an avenue for individuals and small businesses to compare policies and premiums and purchase insurance. For a discussion about the Health Insurance Marketplace go to question 9.

- **Essential health benefits:** The law establishes minimum standards for health insurance plans and requires that they offer 10 categories of essential health benefits (EHBs). For more information about EHBs go to question 13.

- **Employer responsibility:** Often called the “employer mandate,” this requires certain businesses to offer qualifying health care coverage or to pay a penalty. For more information about businesses that are required to offer coverage go to question 34.

A timeline showing the implementation of PPACA is available in Appendix A.

2. **Can individuals with pre-existing conditions be denied health insurance coverage because of those conditions under the federal health care law?**

Beginning in 2014, being sick will not prevent an individual from getting health coverage. An insurer can no longer refuse to offer someone coverage due to a pre-existing condition. Insurers will also be prohibited from charging an individual more because of a pre-existing condition or refusing treatment for pre-existing conditions. A ban on pre-existing condition exclusions for children under 19 began in 2010. Importantly, if an insurer offers pediatric dental benefits through a stand-alone dental plan—i.e., “excepted benefits” not offered as part of a policy covering medical care—the insurer does not have to comply with many PPACA requirements for that plan, including bans on pre-existing condition exclusions. For more information about “excepted benefits,” see question 19.

3. **Can insurers increase premiums based on pre-existing conditions?**

No, unless the premium is for the purchase of a grandfathered plan. Beginning in 2014, health insurers may use modified community rating to vary the premium charged for a non-grandfathered individual or small group plan based on the following factors: **family size** (individual or family), **geography** (rating area), **age** (within a ratio of 3:1 for adults), and **tobacco use** (within a ratio of 1.2:1). For a discussion of grandfathered plans go to question 14.
4. **Am I required to purchase health insurance?**
   Most individuals will have to purchase health insurance or will be subject to a tax penalty. Individuals who are excluded from paying the penalty are:
   - Those who are not required to file taxes.
   - Those with religious objections or who participate in a health care ministry.
   - Those who are members of Native American tribes.
   - Those who go without coverage for less than 3 months.
   - Those who are incarcerated due to a conviction.
   - Those for whom coverage is not affordable. For a discussion of “affordability” go to question 8.
   - Those who have a general hardship exemption that covers unusual circumstances.

5. **What is the penalty?**
   - In 2014, the penalty is the greater of $95 per person or 1 percent of taxable income.
   - In 2015, the penalty is the greater of $325 per person or 2 percent of taxable income.
   - In 2016, the penalty is the greater of $695 per person or 2.5 percent of taxable income.
   - In 2017 and beyond, the size of the penalty is adjusted annually for cost-of-living increases.

6. **Health insurance is expensive. What assistance will be available to help individuals purchase more affordable coverage?**
   Advance premium tax credits, or subsidies, will be available to individuals to help purchase premiums. The federal subsidies are tied to an individual’s household income and the federal poverty level (FPL). Low-income individuals and families earning **above 138 percent of FPL and less than or equal to 400 percent of the FPL** can access the subsidies if they elect to purchase health care insurance via the Health Insurance Marketplace. For a table describing the 2013 FPL scale go to Appendix B, and for a discussion of the Health Insurance Marketplace go to question 9.

7. **How will the subsidies be applied?**
   An individual can elect to apply the subsidies, or tax credits, in advance toward premiums or pay the full premium and apply the credit when he or she files taxes. The subsidies are available on a sliding scale from 139 percent of FPL to 400 percent of FPL, with individuals on the lower end of the FPL scale receiving greater subsidy amounts. Please see Appendix C for a graphic showing the maximum amount of income that must go towards purchasing premiums by FPL level.

8. **The subsidies are supposed to make coverage affordable. How is “affordability” determined?**
   The affordability test differs depending on to whom it is applied.
   - The penalty imposed on individuals for failing to obtain health insurance coverage is not applicable when coverage is not “affordable.” For this purpose, affordability means no more than **8 percent of household income**.
   - To make coverage “affordable,” individuals can qualify for subsidies to purchase health insurance coverage that make coverage “affordable.” Individuals and their families are ineligible for subsidies if they are offered affordable employer-sponsored coverage. For this purpose, affordability means that the cost to the employee of the coverage offered is no more than **9.5 percent of household income**.
   - Employer responsibility penalties can be avoided if an employer makes an offer of coverage that is, among other requirements, “affordable.” For this purpose, affordability means that
the employee’s share of the cost of self-only coverage is no more than **9.5 percent of the employee’s income.** For a discussion of the employer responsibility requirement go to question 34.

9. **What is the Health Insurance Marketplace (HIM)?**
   It is a **competitive online marketplace** where individuals, families, and small employers (with 50 or fewer employees) can **shop for, select, and enroll** in qualified private health plans that meet their specific needs. Individuals may also enroll via paper application, phone, or with the help of trained and licensed assistors. This type of marketplace may sound as if it already exists online; however, the plans offered through the HIM must meet certain regulatory requirements not currently required of plans.

The HIM is also a place where individuals can **determine eligibility** for health insurance premium subsidies and cost sharing reductions or for other state or federal public health programs such as Medicaid. Arkansans can access the HIM via the **Arkansas Health Connector** at www.arhealthconnector.org. For a graphic description of how individuals can enroll see **Appendix D.** For more information about licensed assistors go to question 11.

10. **When can people enroll in coverage through the Health Insurance Marketplace?**
    Individuals, families, and employers may begin enrolling in health care plans via the Arkansas Health Connector beginning **October 1, 2013 through March 31, 2014.** Plan coverage will begin **January 1, 2014.** If an individual enrolls in coverage between October 1 and December 15, 2013, coverage will become effective on January 1, 2014. If an individual enrolls after December 15, 2013 to March 31, 2014, coverage will be effective on either the first day of the following month or the first day of the second following month, depending on if enrollment occurred before or after the 15th of the month.

11. **Not everyone will be able to navigate an online or paper application to enroll. Are there individuals who can help?**
    The state has established an in-person assistance, or **guide** program, to supplement the education efforts of federal navigators. A list of the guide organizations that will hire more than 500 guides to help with enrollment across the state is available at [http://www.hbe.arkansas.gov/FFE/GuideContacts.pdf](http://www.hbe.arkansas.gov/FFE/GuideContacts.pdf). **Navigators** are organizations that are funded by the federal government and available in Arkansas to provide assistance, including in-person help, to consumers and small businesses with the enrollment process. The two navigator organizations helping enroll in the state are the University of Arkansas and Southern United Neighborhoods.

    **Certified application counselors** are individuals in locations such as health care settings or community-based organizations, who are not funded by the state but who are licensed to provide assistance to people needing help applying for coverage. In Arkansas all navigators, guides, and certified application counselors will be trained to provide reliable help to consumers who need it and will be licensed by the Arkansas Insurance Department. Insurance **agents/brokers** may also enroll individuals through the HIM.

12. **Other states have expanded Medicaid under the federal health care law. Did Arkansas?**
    Arkansas took a much different approach than other states. Rather than opting to expand the traditional Medicaid program for adults with **incomes up to 138 percent of FPL** as provided
by the law, Arkansas decided to use that federal funding to allow those individuals to purchase private insurance through the HIM. Commonly called the “private option,” the Arkansas 89th General Assembly passed the Health Care Independence Act of 2013 that authorized the use of the federal funding for this purpose. Individuals eligible for the Health Care Independence program will have the entirety of their premium paid by the program. Those with incomes at or below 100 percent of FPL will also have any cost sharing paid by the program. Those with incomes from 101 percent to 138 percent of FPL will have minimal cost sharing with a maximum out-of-pocket cap on cost sharing at 5 percent of household income. Individuals who have exceptional health care needs and whose care may be better coordinated through traditional Medicaid will be screened out of the program and provided with services through Medicaid. For a graphic description of how individuals can enroll see Appendix D.

13. What are the essential health benefits (EHBs) plans must have?
Except for grandfathered plans, health plans must offer essential health benefits including items and services within at least the following 10 categories: 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 and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. All plans offered through the HIM must include the EHBs unless there are stand-alone pediatric dental and vision plans offered, in which case a medical plan does not have to include those benefits. For more information about the EHBs in Arkansas go to question 17, and for more information about pediatric dental benefits go to question 19.

14. What are “grandfathered” health plans?
Grandfathered health plans are group health plans that were created—or and individual policy purchased—on or before March 23, 2010. Grandfathered plans are exempted from many changes required under PPACA. It is possible for plans to lose grandfathered status if they make significant changes that reduce benefits or increase costs to consumers.

15. What are some of the reasons a plan could lose its “grandfathered” status?
A plan will lose its grandfathered status if any of the following occur:

- The percentage of coinsurance is increased.
- Deductibles or out-of-pocket limits have a cumulative increase greater than the medical price inflation plus 15 percentage points.
- The employer contribution to the employee premium decreases by more than 5 percentage points.
- Any increase in copays above the level in effect on March 23, 2010, by an amount that exceeds the greater of the sum of medical inflation plus 15 percent or $5 multiplied by medical inflation plus $5.

16. How are “grandfathered” plans different from plans created after March 23, 2010?
All health plans must end lifetime limits on coverage and arbitrary cancellations of health coverage; cover adult children up to age 26; provide a summary of benefits; and spend the majority of premium payments on health care, not administrative costs and bonuses.
Grandfathered plans do not have to cover preventive care at no out-of-pocket cost, guarantee the right to appeal decisions made by the health plan, or be held accountable through rate review for excessive premium increases. In addition to the above, grandfathered individual health plans do not have to end annual limits on coverage expenditures or cover someone if he or she has a pre-existing health condition.

17. How are the essential health benefits (EHBs) defined in Arkansas?

Rather than adopting a national standard for EHBs, the U.S. Department of Health and Human Services provided flexibility and allowed each state to choose its own benchmark plan for EHBs. The Arkansas Insurance Department (AID) announced the EHB benchmark plan selection on September 21, 2012. To meet all of the 10 categories of EHBs, AID selected Arkansas Blue Cross Blue Shield Health Advantage Point of Service Plan (POS) as the foundation for the benchmark plan and supplemented it with the following:

- QualChoice Federal Plan Mental Health and Substance Abuse Benefits for the mental health benefit due to the POS plan’s not being sufficient to meet the federal requirements
- Arkansas Children’s Health Insurance Program (CHIP), ARKids First for the pediatric dental benefit, which was absent from the POS plan
- Arkansas Blue Cross Blue Shield Federal Pediatric Vision Plan, which was absent from the POS plan

Details related to each of these plans may be found at http://hbe.arkansas.gov/. For more information on the pediatric dental benefit go to question 19.

18. Will plan cost sharing differ among plans offered through the HIM?

Yes. The HIM has established tiers (bronze, silver, gold and platinum), which are ways to categorize plans based on “actuarial value.” Actuarial value (AV) measures the relative generosity of the health plan’s coverage of the EHBs. A plan’s AV indicates the share of medical spending paid by the plan rather than being paid out-of-pocket by the consumer (such as deductibles, coinsurance, co-payments, and out-of-pocket limits), measured across a covered population. The AV required by tier is as follows: bronze (60 percent), silver (70 percent), gold (80 percent), and platinum (90 percent). There are no annual or lifetime caps on expenditures for these plans, and beneficiary out-of-pocket costs for 2014 are capped at $6,350 for an individual and $12,700 for a family. Those totals include copayments and deductibles but not premiums, and they apply only to plans that are not grandfathered. Certain employer-sponsored plans have been exempted from this requirement for 2014.

A plan’s minimum AV must be at least 60 percent. An AV of 60 percent means that a customer is responsible for 40 percent of the costs of all benefits covered under that plan. All non-grandfathered plans sold to individuals and small groups must fall into one of four tiers.

PPACA and Pediatric Dental Benefits

19. Will insurers offering health plans through the HIM be required to offer pediatric dental benefits?

PPACA outlines the requirements for plans to cover the 10 categories of the EHBs, including pediatric oral and vision care. Pediatric dental (and vision) benefits will be available through the HIM and may be offered either as part of an embedded plan or as a stand-alone product.
• **Example of Embedded Plan:** QualChoice has a medical plan that offers all 10 EHBs, including pediatric dental and vision coverage, available for a single premium.

• **Example of Stand-Alone Option:** Delta Dental offers a stand-alone pediatric dental plan that has a premium; Best Life and Health Offers a stand-alone pediatric vision plan that has a separate premium; and QualChoice offers the remaining EHBs through a medical plan that has a separate premium.

If a stand-alone pediatric dental (or vision) option is separately available from any carrier through the HIM, insurers offering medical plans are not required to offer those benefits as part of an embedded product. Whether pediatric dental benefits are embedded or offered as a stand-alone product is an important factor relating to mandatory purchase. *For more information about the requirement to purchase go to question 21.*

How the pediatric dental benefit is offered is also important as it relates to other PPACA requirements. Pediatric dental (and vision) benefits offered as stand-alone products are “excepted benefits” as defined by the Health Insurance Portability and Accountability Act (HIPAA) and as such are not required to comply with certain PPACA requirements imposed on medical plans, such as bans on pre-existing condition exclusions and prohibitions on lifetime and annual caps on plan expenditures. Under HIPAA, dental (and vision) benefits generally constitute excepted benefits if they are offered under a separate policy, certificate, or contract of insurance or are not an integral part of the plan. For dental (or vision) benefits to be considered not an integral part of the plan, participants must have a right not to receive the coverage and, if they do elect to receive the coverage, must pay an additional premium.

**20. Are insurers planning to offer pediatric dental coverage through the HIM?**

Yes, but only as a stand-alone product. Insurers planning to offer stand-alone pediatric dental plans are Arkansas Blue Cross Blue Shield, Best Life and Health, Delta Dental of Arkansas, Dentegra Insurance Company, Guardian Life Insurance Company, Lincoln National Life Insurance Company, and Renaissance. Insurers opting to offer adult dental coverage through the HIM must do so by attaching the coverage to a pediatric dental plan and may not offer a stand-alone adult dental product.

**21. Are individuals required to purchase the stand-alone pediatric dental benefit when purchasing coverage through the HIM?**

No. While PPACA requires that the full set of EHBs are offered to people purchasing coverage through the HIM, nothing in the law requires the purchase of the full set of EHBs if the individual purchases through the HIM. Thus, someone (with a child or without) can purchase coverage through the HIM that does not include the pediatric dental benefit and can bypass the purchase of a stand-alone pediatric dental plan.

**22. Are there any requirements on what must be offered in a stand-alone pediatric dental benefit?**

The minimum required benefit structure for stand-alone pediatric dental plans offered through the HIM is modeled after the Children’s Health Insurance Program (CHIP), or ARKids B. Covered benefits include the following:

- One office visit, one cleaning, one set of x-rays, and one fluoride treatment every six months
• Panoramic x-ray or full mouth series of x-rays
• Dental sealants for 1st and 2nd permanent molars only
• Simple and surgical tooth pulling
• Fillings, crowns, and root canals

Orthodontic care is not covered by ARKids B. Therefore, it is not a required offering by stand-alone pediatric dental plans. Stand-alone pediatric dental plans must offer benefits at either a low level of coverage with an AV of 70 percent or a high level of coverage with an AV of 85 percent. The plans must demonstrate that they have a reasonable annual limitation on cost sharing. For 2014, “reasonable” is any annual limitation on cost sharing that is at or below $700 for a plan with one child enrollee or $1,400 for a plan with two or more child enrollees. Cost sharing associated with pediatric dental is not applied toward the out-of-pocket maximum required of medical plans offered through the HIM. For more information about the out-of-pocket maximum go to question 18.

Stand-alone pediatric dental plans are required to cover dependents to age 19. (Eligible 19- and 20-year olds who require medically necessary services through the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program may receive those services through Medicaid.)

23. Without obtaining the pediatric dental benefit, will an individual be subject to a penalty for failing to purchase EHBs?
No. Individuals are responsible for obtaining only “minimum essential coverage,” not for obtaining coverage with all EHBs. “Minimum essential coverage” is a PPACA definition that refers to the coverage needed to avoid the individual responsibility penalty. A purchased plan does not have to include EHBs to meet the definition of minimum essential coverage.

24. What about plans offered outside the HIM?
Outside the HIM, the requirements work a bit differently. PPACA has no provision that exempts non-HIM medical plans from offering all EHBs based on the availability of a stand-alone dental plan in the market. Consequently, carriers must assure that consumers have access to all of the EHBs, including pediatric dental coverage. U.S. DHHS has concluded that in order to offer HIM-certified plans outside the HIM, insurers do not have to offer pediatric dental benefits but must be “reasonably assured” that consumers have purchased pediatric dental coverage. Technically this should have the effect of requiring families to obtain pediatric dental coverage if they want to purchase medical benefits outside of the HIM. What the practical effect of this requirement is and how it will be enforced remains uncertain.

25. Will the subsidies apply toward the purchase of the stand-alone pediatric dental plans offered through the HIM?
Premiums for stand-alone pediatric EHB products are not included when calculating the subsidies. Because stand-alone pediatric dental plans are offered not as part of medical plans, the premiums for pediatric dental plans—calculated and presented separately—are not considered part of the second lowest silver plan (see question 18 for a description of bronze, silver, gold, and premium metal levels), which is the plan used to calculate subsidies. Even so, initial federal guidance indicates that a percentage of the subsidy received may go toward the purchase of a pediatric dental plan.
### PPACA and Dental Plans Generally

**26. Can consumers use subsidies toward the purchase of adult dental benefits?**

Adults wanting dental coverage through the HIM **may not use subsidies toward the purchase of the adult benefits**, even if the plan is attached to pediatric dental benefits. Also, any benefits in addition to the pediatric dental EHBs will not qualify for subsidies.

**27. To be reimbursed will dentists be required to be in the insurers’ network of providers for plans offered through the HIM?**

Insurers will operate similar to the way they operate in Arkansas at the present time. Insurers can negotiate with dentists to become a part of the provider networks, and it is between the provider and the insurance company as to what fee schedule is negotiated.

**28. What if an individual with a dental plan offered through the HIM chooses to go to a dentist outside the network?**

Whether services from providers outside of the plan’s network are covered and at what cost to the beneficiary depends on the terms of each individual policy.

**29. What fee schedules are the insurers offering dental coverage using?**

The fee schedules used by the insurers are **not available at this time** and depend upon negotiations between individual dentists/groups and the insurers themselves. The HIM has no requirements relating to provider payment rates.

**30. Are premiums for the plans known?**

Although the names of the insurers intending to offer plans through the HIM are available, the premiums and information about the plans’ benefit structure will not be available until open enrollment begins on October 1, 2013.

**31. Are there any expected changes to dental coverage available to children through ARKids First or the adult Medicaid dental program as a result of PPACA or the Health Care Independence Act?**

At this time there are **no expected changes to current dental coverage offered through Medicaid**, although estimates have shown that the Medicaid program can expect additional enrollees due to the “woodwork” or “welcome mat” effect created by PPACA and the Health Insurance Marketplace. Importantly, the Health Care Independence Act calls on the Arkansas Department of Human Services to seek a waiver to transition ARKids B enrollees into plans offered through the HIM in 2015, but the details regarding transition plans are not available at this time.

**32. Are there estimates of the number of uninsured Arkansans obtaining health care coverage in 2014? Are there projections for new enrollment in pediatric dental coverage?**

An ACHI-sponsored RAND study has indicated that an estimated 571,000 Arkansans would have been without health insurance in 2016 absent expanded coverage under PPACA. The study estimates that **400,000 individuals will obtain coverage** either through funding from Medicaid or by purchasing with subsidies through the HIM. The study includes county-specific estimates of expanded coverage, economic impact projections, and estimates of lives saved as a result of
expanded coverage. It is available at http://www.achi.net/MiscDocs/130103RAND%20Final.pdf.

An April 2013 study by the American Dental Association estimated that by 2018 approximately 29,000 Arkansas children would gain pediatric dental coverage through the HIM as a result of PPACA. A major assumption of the study, however, was that the purchase of pediatric dental benefits through the HIM would be mandatory as part of the EHBs. Consequently, the study overestimates the number of children expected to gain dental coverage through the HIM. The study also estimated that by 2018 an additional 7,600 adult Arkansans would obtain dental coverage through the HIM, even absent mandatory purchase. The study used the Medical Expenditure Panel Survey, U.S. Census, comprehensive claims, and market research data to make projections. It is available at http://www.ada.org/sections/professionalResources/pdfs/HPRCBrief_0413_3.pdf.

33. **Is there any PPACA funding for building capacity in the dental workforce to absorb potential additional demand for services?**

PPACA offers funding for 17 programs dealing with health care workforce issues, two of which focus on dentistry. The two programs for which PPACA offers funding are a **training program for general, pediatric, and public health dentistry** and a **demonstration program for alternative dental health care providers**. The former program authorizes grants or contracts to dental and dental hygiene schools; residencies; and advanced programs in general, pediatric, or public health dentistry for the purposes of faculty development, loan repayment, and pre-and post-doctoral training programs in primary dental care. The latter program authorizes the award of 15 five-year grants of not less than $4 million to train or employ alternative dental care providers to increase access to dental services in underserved areas. No funds have been appropriated for these programs at this time.

**Requirements for Dentists as Employers**

34. **As an employer, am I required to provide health insurance to the employees at my practice?**

Often called the employer mandate, PPACA requires every employer with **50 or more full-time equivalent (FTE) employees** to offer affordable health insurance with minimum essential coverage to full-time employees or pay a penalty if any full-time employees receive a premium subsidy through the HIM. *(Please refer to the graphic in Appendix E for help to determine whether you are an employer required to offer coverage.)* The enforcement of **penalties associated with the employer mandate has been delayed until 2015**, and employers will not face a penalty for failing to offer coverage to full-time employees during 2014.

35. **How do I count my employees to determine whether I have to offer coverage?**

A full-time employee is defined as any employee who works an **average of 30 hours or more per week**. Employers can use a retrospective measurement period lasting between three and 12 months to determine whether an employee's hours meet the definition. Calculations including part-time employees are a bit more complex. Please see Appendix F for further information on calculating FTEs.
36. What type of coverage do I have to offer?
If you are an employer of 50 or more FTEs, then you must offer full-time employees “minimum essential coverage.” Minimum essential coverage generally includes Medicare, Medicaid, plans offered through the HIM, or any employer-sponsored plan offered in the small or large group markets. Employer-sponsored coverage must have a minimum AV of at least 60 percent (i.e., it has at least the AV of a bronze plan through the HIM). Excepted benefits, such as limited-scope dental or vision offered under a separate policy do not qualify.

37. I struggle to offer health insurance to my employees. Is there any financial assistance to small employers?
Yes. You may be eligible for tax credits to help with the purchase of health insurance for your employees if you meet all of the following requirements:

- Cover at least 50 percent of the cost of employee-only coverage for each of your full-time employees
- Have fewer than 25 FTEs
- Have employees whose average wages are less than $50,000 per year
- Purchase coverage through the Small Business Health Options Program (SHOP) Marketplace

Please see the Internal Revenue Service (IRS) website at http://www.irs.gov/uac/Small-Business-Health-Care-Tax-Credit-for-Small-Employers for additional details.

38. What is the Small Business Health Options Program (SHOP)?
It is just like the marketplace for individuals, except this one is expressly for small businesses. The SHOP will be available for small businesses to compare plans beginning October 1, 2013.

39. What are the qualifications for an employer to participate in the SHOP?
Your practice is eligible to participate in the SHOP for the applicable year if you meet all of the following criteria:

- In 2014 and 2015, you have 50 or fewer FTEs employed
- In 2016, you have 100 or fewer FTEs employed.
- You offer coverage to all full-time employees.
- At least 70 percent of your full-time employees enroll in your SHOP plan.

40. Should I be aware of any other employer requirements related to the law?
Yes. A notice must be sent to current employees by October 1, 2013 and within 14 days to newly hired employees. The notice must:

1) Contain an explanation of how the employee may be eligible for a subsidy or a cost sharing reduction if the employer’s plan does not meet certain requirements
2) Inform employees that if a qualified health plan is purchased through the HIM, then they may lose any employer contribution toward the cost of employer-provided coverage, and that all or a portion of the employer contribution to employer-provided coverage may be excludable for federal income tax purposes
3) Include contact information for customer service resources within the HIM, and an explanation of appeal rights
4) Meet certain accessibility and readability requirements
5) Be in writing

Please see the notice issued by the Department of Labor concerning those businesses that offer health insurance for more information: [http://www.dol.gov/ebsa/pdf/FLSWithplans.pdf](http://www.dol.gov/ebsa/pdf/FLSWithplans.pdf). Please see the following notice issued by the Department of Labor concerning those businesses that do not offer health insurance for more information: [http://www.dol.gov/ebsa/pdf/FLSWithoutplans.pdf](http://www.dol.gov/ebsa/pdf/FLSWithoutplans.pdf).