The Impact of the Patient Protection and Affordable Care Act on Dental and Vision Benefits

It has been well documented that The Patient Protection and Affordable Care Act (PPACA) imposes significant new requirements on group health plans. While most of the attention has been on medical and pharmacy plans, the law also addressed dental and vision plans. The good news is that according to the new law, plans providing insured dental and vision benefits are not subject to the provisions of PPACA. Also, plans that are self-insured but subject to a participant election and participant contributions, are not subject to PPACA. However, the law says that self-insured dental and vision benefits that are not separately elected and do not have separate participant contributions must comply with PPACA.

Due to the greater attention paid to the larger core programs, employers and plan sponsors with dental or vision benefits have struggled to determine how the new federal law will affect their benefits. Specific guidance can be found in regulations published several years ago that define which group health plans are subject to the portability requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Since HIPAA and PPACA generally both apply to “group health plans” as defined under HIPAA, plans that are not subject to the HIPAA portability rules are also not subject to PPACA. Certain benefits that are not subject to the HIPAA portability rules are known as “excepted benefits.”

Limited Scope Dental and Vision Benefits

There are several categories of excepted benefits under HIPAA, including benefits such as long-term care, along with “limited-scope dental and vision benefits” and “limited-scope vision benefits.” Group health plan benefits may be considered limited-scope, and as a result not subject to HIPAA or PPACA, in *either* of the two following situations:

1. They are provided under a separate policy, certificate or contract of insurance (meaning an insured product like dental insurance or vision insurance), or
2. They are not otherwise an integral part of a group health plan.

To meet this second test, which is the one that would apply if the dental or vision benefits are provided on a self-insured basis, participants must have the right to elect not to receive the coverage, and a participant who elects the coverage must pay an additional premium or make a contribution for that coverage. For purposes of this test, it does not matter whether the dental or vision benefits are provided through the same plan as the underlying medical coverage or through a separate plan. It also does not matter whether the benefits are a self-administrator or

administrative-services-only arrangement.

In a recent Frequentlyl Asked Question, the Department of Labor (DOL) clarified that the HIPAA definition of limited-scope applies to dental and vision plans and determines whether they must comply with PPACA. The DOL also stated that if a plan provides its dental or vision benefits pursuant to a separate election by a participant and the plan charges “even a nominal employee contribution” toward the coverage, the dental or vision benefits would be excepted from PPACA's group health plan mandates. As a result, plans that provide dental and vision benefits that are insured or that are self-insured, but subject to a participant election and participant contribution, are not subject to PPACA. However, self-insured dental and vision benefits that are not separately elected and paid for must comply with PPACA.

Dependent to 26 Mandate

Employers and plan sponsors that offer dental and vision benefits will need to comply with the age-26 mandate if the dental/vision plan does not fit within the HIPAA definition of an excepted benefit. This provides for continuation of coverage for children until they reach age 26. Also, certain children and their parent(s) (if not already covered) are offered a new, one-time special enrollment opportunity with coverage effective as of the first day of the plan year beginning on or after September 23, 2010. Coverage may be provided on a tax-free basis to the child until the end of the year in which the child turns 26.

Lifetime and Annual Limits for Dental and Vision Plans

Dental and vision plans often have various types of annual and lifetime dollar limits. The PPACA bans lifetime dollar limits (and regulates annual dollar benefits) on “essential health benefits,” a term that is defined in the law to include “pediatric services, including oral and vision care.” The federal agencies have stated in regulations that until the agencies provide definition of “essential benefits,” a plan sponsor may make a reasonable judgment about what constitutes an essential benefit. Because pediatric dental and vision benefits are listed as an essential benefit in the statute, it appears that these benefits cannot have a lifetime dollar limit or an annual dollar limit lower than the restricted annual dollar limit ($750,000 for plan years beginning on or after September 23, 2010; $1.25 million and $2 million for plan years beginning on or after September 23, 2011 and 2012, respectively, and must be unlimited for plan years beginning on or after September 23, 2013). As a result, many employers and plan sponsors with non-excepted dental and vision plans are removing dollar limits on pediatric dental and vision benefits.

Among the factors to consider when implementing this requirement are the following:

- **Are orthodontia benefits considered to be “essential pediatric dental benefits”?** Plan sponsors can make a reasonable judgment on this issue. They may wish to consider whether they currently cover orthodontia, what similar plans provide and what the needs of their population may be. Plan sponsors may also wish to consider whether orthodontia would be paid differently for pediatric care than for adult care.
- **Are adult dental and vision benefits “essential benefits”?** These benefits are not listed as essential in the statute, so if they are not essential it is likely that lifetime and annual dollar limits could be maintained for adult services.
- **What age will the plan use to define “pediatric”?** Options could include 18 or 21 years, or the age of majority in a particular state.
- **What type of visit or treatment limitations may be appropriate to control costs?** This is a particularly important question with respect to the cost of glasses for pediatric care

because they may have previously been subject to an annual dollar maximum. Under the new law that maximum can no longer apply unless vision services are excepted. Generally, a treatment or visit limit on a particular service (e.g., two cleanings per year, one pair of eyeglasses every two years, and eye exam every year) would be permissible, as long as there is not also a dollar limit on the service. For example, payment of two cleanings per year at the plan's allowable charge would appear to be permissible. However, payment of two cleanings per year at $50 or $75 per cleaning would not because the resulting $100 payment amount would be an annual dollar limit.

If you need assistance with evaluating your dental and/or vision plans due to the impact of the PPACA, please contact your Conner Strong & Buckelew account representative.

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