



Impact of the Affordable Care Act on Dental and Vision Benefits

As discussed in previous issues of *Health Care Reform Insights*, the Affordable Care Act¹ imposes significant new requirements on group health plans, including “grandfathered” plans (those plans in existence when the law was enacted). Guidance from the agencies implementing the Affordable Care Act confirms that:

- Plans providing insured dental and vision benefits are not subject to the Affordable Care Act.
- Plans that are self-insured but subject to a participant election and participant contributions are not subject to the Act.
- Self-insured dental and vision benefits that are not separately elected and do not have separate participant contributions must comply with the Affordable Care Act.

This issue of *Health Care Reform Insights* addresses how those requirements, including the mandate to continue coverage of children up to age 26 and the ban on lifetime dollar limits, affect dental and vision benefits offered by group health plans.

Background

Plan sponsors with dental or vision benefits have struggled to determine how the Affordable Care Act will affect these benefits. Guidance can be found in regulations published several years ago that define which group health plans are subject to the portability requirements² of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Since HIPAA and the Affordable Care Act 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 the Affordable Care Act. Certain benefits that are not subject to HIPAA portability rules are known as “excepted benefits.”³

There are several categories of excepted benefits under HIPAA, including benefits such as long-term care, along with “limited-scope dental benefits” and “limited-scope vision benefits.”

Limited-Scope Dental and Vision Defined

Group health plan benefits may be considered limited-scope, and, therefore, not subject to HIPAA or the Affordable Care Act, in *either* of the two following situations:

- They are provided under a separate policy, certificate or contract of insurance (meaning an insured product like dental insurance or vision insurance), **or**
- 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

¹ The Affordable Care Act is the abbreviated name for the new health care reform law, the Patient Protection and Affordable Care Act (PPACA), Public Law No. 111-48, as modified by the subsequently enacted Health Care and Education Reconciliation Act (HCERA), Public Law No. 111-52.

² HIPAA’s portability requirements include limitations on preexisting conditions, special enrollment for acquiring a new dependent or losing other coverage, and certification of creditable coverage.

³ These benefits are also not subject to subsequently enacted laws mandating requirements for health plans (e.g., the Women’s Health and Cancer Rights Act and the Mental Health Parity and Addiction Equity Act).

coverage or through a separate plan. It also does not matter whether the benefits are self-administered or administered by a third-party administrator or administrative-services-only arrangement.

In a publication called “Frequently Asked Questions about the Affordable Care Act Implementation Part II,” 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 the Affordable Care Act.⁴ 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 the Affordable Care Act’s group health plan mandates.

Consequently, 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 the Affordable Care Act. However, self-insured dental and vision benefits that are not separately elected and paid for must comply with the Affordable Care Act.

Lifetime and Annual Limits

Dental and vision plans often have various types of annual and lifetime dollar limits. The Affordable Care Act 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.”⁵ The federal agencies have stated in regulations that until the agencies provide a definition of “essential benefits,” a plan sponsor may make a reasonable judgment about what constitutes an essential benefit.⁶

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). Consequently, many 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:

- **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.
- **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, lifetime and annual dollar limits could be retained for adult services.

⁴ That publication is on the following page of the DOL’s Web site: <http://www.dol.gov/ebsa/faqs/faq-aca2.html>

⁵ The Affordable Care Act’s provision on lifetime/annual dollar limits (new PHS §2711, created by PPACA §1001) references the definition of “essential health benefits” found in PPACA §1302(b). This list of essential health benefits is the list of benefits that must be offered by qualified health plans sold within the health insurance exchanges that will begin to operate in 2014. For more information about the provision on lifetime/annual dollar limits, see Segal’s May 2010 *Health Care Reform Insights*, “Prohibition on Lifetime and Annual Limits”: <http://www.segalco.com/publications/HCRI/may2010limits.pdf>

⁶ See regulations defining annual and lifetime dollar limit rules, which were published in the June 28, 2010 issue of the *Federal Register*: <http://edocket.access.gpo.gov/2010/pdf/2010-15278.pdf>

- **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, an 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 per cleaning would not, because the resulting \$100 payment amount would be an annual dollar limit.

Age-26 Mandate

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 means continuing coverage for children until they reach age 26 and providing certain children – and their parent(s), if not already covered – with a new one-time special enrollment opportunity to enroll in the plan with coverage effective as of the first day of the plan year beginning on or after September 23, 2010.⁷ Coverage may be provided on a tax-free basis to the child until the end of the year in which the child turns 26.

Action Steps for Plan Sponsors

When considering how dental and vision coverage is affected by the Affordable Care Act, plan sponsors need to do the following:

- Determine whether the plan's dental and/or vision benefits fit within the existing definition of an "excepted benefit."
- Consider plan design changes needed to comply with the applicable Affordable Care Act provisions, if the dental and/or vision benefit is not an "excepted benefit."
- Change to an insured dental or vision benefit, if that makes sense for the plan. Some plan sponsors may wish to consider this option in order to preserve the current plan design.
- Meet with the plan's dental and vision claims administrators to assure that the Affordable Care Act is being implemented correctly and consistently, including any of the decisions on plan design changes noted above.
- Amend dental and vision plan documents, including summary plan descriptions.
- Communicate plan changes to participants. Make sure that special enrollment language in the plan's enrollment materials takes the dental/vision plan into account and tells participants whether adult children can enroll in dental/vision as well as medical.

⁷ For more information about the age-26 mandate, see Segal's November 2010 *Health Care Reform Insights*, "Agencies Continue to Clarify Rules on Coverage for Children": <http://www.segalco.com/publications/HCRI/nov2010DepCov.pdf>

Plan sponsors should rely on their attorneys for authoritative advice on the interpretation and application of the sweeping national health care reform law. Segal can be retained to work with plan sponsors and their attorneys on compliance issues. In addition, Segal can help plan sponsors to evaluate their current plan design and draft participant communications. Segal will keep clients informed as additional regulations are issued.