Limited Scope Dental and Vision Benefits

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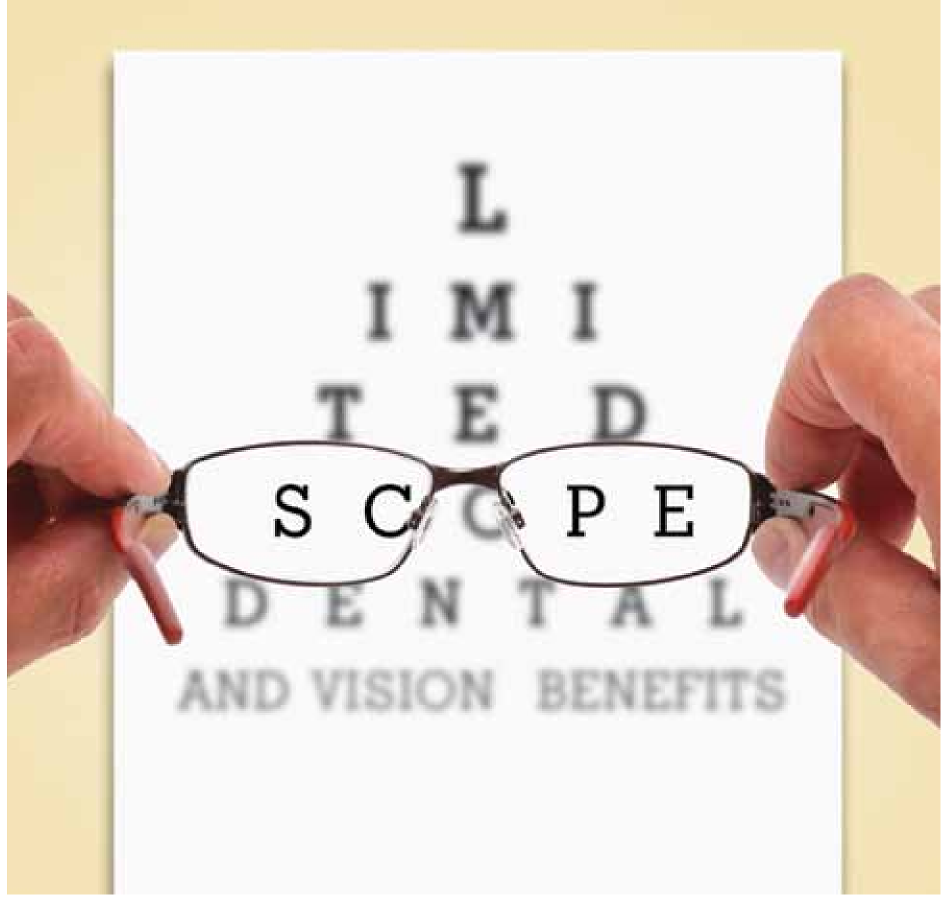
Limited scope dental benefits cover substantially all treatment of the mouth (including any organ or structure within the mouth), and limited scope vision benefits cover substantially all treatment of the eye. In the 2004 preamble to the regulations defining limited scope dental and vision benefits, the U.S. Department of Labor (DOL) indicated that a policy can still qualify as a limited scope dental benefit even though it provides coverage of such things as oral cancer or for a mouth injury that results in broken, displaced, or lost teeth, or as providing limited scope vision benefits even though it covers such ophthalmological services as treatment of an eye disease, such as glaucoma, a bacterial eye infection, or an eye injury.[1]



Limited scope dental and limited scope vision benefits are excluded from the Employee Retirement Income Security Act (ERISA) and Internal Revenue Code's (Code) group health plan requirements, including the group health plan portability access and renewability requirements initially enacted as part of the Health Insurance Portability and Accountability Act (HIPAA). Whether or not they qualify as grandfathered plans, they are also excluded from the market reform provisions enacted by the Patient Protection and Affordability Care Act (ACA)[2] if they are provided under a separate policy, certificate, or contract of insurance, or are otherwise not an integral part of the plan. PEOs with fully insured dental plans administered by dental plan carriers will satisfy the first prong. Self-funded dental plans will not satisfy the separate contract of insurance requirement, even if they have contracts with carriers to administer the dental plans, because that contract is a contract for administrative services rather than a contract of insurance. Benefits are considered to be an integral part of a plan unless a participant has the right to elect not to receive coverage for the benefit and, if the participant elects to receive coverage for the benefit, the participant pays an additional premium or contribution for that benefit. In an October 8, 2010, question and answer document from the U.S. Departments of Health and Human Services (HHS), Labor, and Treasury, the following additional gloss was provided on whether dental or vision benefits are integral:

"Accordingly, 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

1 Quoted in RIA Benefit Analysis ¶110. 138.2.

2 The ACA market reforms that will not apply to dental and vision benefits that are excepted benefits include: no annual and lifetime limit on benefits; dependents retaining eligibility until age 26; mandatory coverage of preventive services with no cost sharing; mandatory external review of adverse claims determinations; no preexisting conditions exclusions; no waiting period exceeding 90 days; and guaranteed issue and renewal.

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vision) benefits would constitute excepted benefits, and the market reform provisions would not apply to the coverage."[3]

In contrast, if a self-insured dental or vision benefit automatically covers all group health plan participants, it is not an excepted benefit, even if a separate premium is attributed to that benefit.

PEOs should note that, even though limited scope dental and vision benefits are excepted benefits, pediatric dental and pediatric vision benefits are essential health benefits[4] under the ACA. Therefore, if the plan is part of the small group insurance market, i.e., if the employer (determined on a controlled group basis) has 50 or fewer employees, it will only be able to purchase health coverage outside of an exchange[5] that includes both pediatric dental and pediatric vision. (Generally, essential health benefits and pediatric dental benefits are provided up to age 19, unless a state elects a higher age. For example, in Kentucky, pediatric dental coverage must be provided until age 21.) Self-funded dental plans and fully insured dental plans in the large group market (in most states, groups that have more than 50 employees) are not required to provide essential health benefits, and thus are not required to provide essential health benefit compliant pediatric dental and pediatric vision benefits.

Individuals enrolled in both a qualified health plan and a pediatric dental plan may not receive a cost-sharing subsidy for the pediatric dental benefits that are included in the essential health benefits the qualified health plan is required to provide. PPACA Section 1402(c)(5). If a separate out-of-pocket maximum applies to pediatric dentistry, that maximum cannot exceed the dollar amount for transitional relief on out-of-pocked maximums for 2014. (For a stand-alone dental plan on an exchange covering the pediatric dental essential health benefit, cost sharing in 2015 may not exceed $300 for a covered child and $400 for two or more covered children. Prop. Reg. HHS 45 C.F.R. § 156.150(a).)

Specific Issues Under the ACA

- For the information reporting to employees of the cost of employer sponsored group health plan coverage that is required under Code Section 6051(a)(14), in Q&A 20 of Notice 2012-9, the IRS indicated that an employer is not required to include the cost of coverage under a dental plan or vision plan that is an excepted benefit under the HIPAA regulations, but is required to include the cost of coverage under a dental or vision plan that does not satisfy the requirements for an excepted benefit.
- The ACA imposes four new taxes: the health insurance provider fee, the medical device excise tax, the Patient Centered Outcome Research Institution (PCORI) fee, and the transitional reinsurance fee. The health insurance provider fee applies to stand-alone dental and vision arrangements.[6] The medical device excise tax, a 2.3 percent excise tax on the sales price of taxable medical devices, would apply to stand-alone dental and vision plans, but it is unlikely to have an effect on sponsors of dental plans or vision plans, particularly because eyeglasses and contact lenses are specifically exempted from the tax. Neither the PCORI fee nor transitional

3 Delta Dental of Michigan—Affordable Care Act FAQs, Q&A 3. In proposed regulations issued by the agencies in December 2013, the requirement that participants in self-insured plans pay an additional premium for limited-scope vision or dental benefits to qualify as benefits that are not an integral part of a plan (and therefore qualify as excepted benefits) was eliminated. Until rulemaking is finalized, through at least 2014, for purposes of the market reform provision of the PPACA, the agencies will consider dental and vision benefits meeting the conditions of the proposed regulations to qualify as excepted benefits. To the extent that final regulations or other guidance with respect to vision and dental benefits is more restrictive than the proposed regulations, the final regulations will not be effective prior to January 1, 2015.

4 Only pediatric orthodontia that is medically necessary, such as coverage related to a cleft palate condition, would be an essential health benefit under the ACA.

5 In the private markets, under HHS regulation, a medical plan can exclude pediatric dental if the medical carrier is "reasonably assured" that individuals have obtained pediatric dental coverage through a certified stand-alone dental plan.

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reinsurance fee apply to dental plans and vision plans that are excepted.

- Code Section 45R offers a tax credit to certain small employers that provide health insurance coverage for their employees. Beginning in 2014, the coverage must be provided through an exchange. Health insurance coverage for purposes of Code Section 45R credit prior to 2014 included limited scope dental or vision; long-term care, nursing home care, home healthcare, community-based care, or any combination thereof; coverage only for a specific disease or illness; and hospital indemnity or other fixed indemnity insurance. Commencing in 2014, of these ancillary benefits, only stand-alone dental policies offered on an exchange can be taken into account for purposes of the Code.[7]
- Different types of health insurance plans are not aggregated for purposes of meeting the qualifying arrangement requirement under Code Section 45R. For example, if an employer offers a major medical insurance plan and a stand-alone vision plan, the employer must separately satisfy the requirements for a qualifying arrangement with respect to each type of coverage.
- The exclusion from the Code Section 4980I excise tax on high-cost employer-sponsored health plans, i.e., "Cadillac plans," for dental and vision benefits does not apply to limited scope dental and vision benefits that are not an integral part of a group health plan, but rather is limited to any coverage under a separate policy, certificate, or contract of insurance that provides benefits substantially all of which are for the treatment of the mouth (including any organ or structure within the mouth) or treatment of the eye. Code Section 4980I(d)(1)(B)(ii).
- In the preamble to the final regulations dealing with the obligation to provide a summary of benefits and coverage (SBC) (February 14, 2012), the agencies stated that, "an SBC need not be provided for stand-alone dental or vision plans or health FSAs if they constitute excepted benefits under the Department's regulations."

Outside of the ACA

Consolidated Omnibus Budget Reconciliation Act (COBRA)

An employer's limited scope dental plans and vision care plans qualify as group health plans for COBRA purposes because they provide medical care. The definition of group health plan for purposes of COBRA does not contain any exception for limited purpose plans, as does the HIPAA definition.

As a general rule, all health benefits provided by an entity are treated under the COBRA regulations as being provided under one group health plan. This default rule applies unless it is clear from the governing instruments that the benefits are being provided under separate plans, and the arrangements are operated pursuant to such instruments as separate plans. If a PEO maintains two separate plans, one providing medical benefits and the other providing dental benefits, the PEO must provide a qualified beneficiary with a choice of COBRA continuation coverage for either the medical plan or the dental plan, or both plans.

HIPAA Privacy Rules

Health plans are one of the covered entities subject to the HIPAA privacy rules, and these include limited scope dental and vision benefits. As noted above, these benefits were excluded from HIPAA's portability rules, but were not excluded from the administrative signification provisions, i.e., the HIPAA privacy and security rules and the electronic data interchange rules. The extent to which the HIPAA Privacy Rules affect a limited scope dental plan depends upon both the nature of the plan and the PEO's relationship to the client company. If a limited scope dental or vision plan only provides insurance or coverage through a health insurer or an HMO, and does not create, maintain, or receive protected health information (PHI), it is not required to meet the privacy rules' administrative requirements. The insurer or HMO will satisfy those requirements. However, if the PEO maintains a health flexible spending account (FSA) that covers dental benefits, it will be subject to the full range of HIPAA privacy requirements, although it may contract with a TPA/business associate to perform many of the functions. If the dental plan is self-funded, the PEO will be subject to all of the HIPAA privacy requirements. This will also be the case if the client company maintains its own health plan and the PEO acts as a business associate in connection with the administration of the plan. Although not the subject of this article, PEOs that act as business associates should be aware of the significantly increased responsibilities they have under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009.

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This article is designed to give general and timely information about the subjects covered. It is not intended as legal advice or assistance with individual problems. Readers should consult competent counsel of their own choosing about how the matters relate to their own affairs.

6 Note that the proposed health insurance provider fee regulations exclude from health insurance for purposes of the health insurer's provider fee: the ancillary benefits for long-term care, nursing home care, community based care, or a combination thereof; coverage only for a specific disease or illness; and hospital indemnity or other fixed indemnity insurance.

7 Unlike stand-alone dental plans, stand-alone vision plans and other ancillary insurance products such as disability or life insurance cannot be offered in or through an exchange, although states have the discretion to offer them through separate state programs that share resources and infrastructures with a state-based exchange. However, an exchange may provide basic information about vision or other ancillary insurance products on an exchange website. See C.M.S. Frequently Asked Questions on Reuse of Exchange for Ancillary Products (March 29, 2013).

further reading

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