

Dispelling Misconceptions:

How Dental and Vision Coverage Fits Within the ACA



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Across the country, people have been anticipating changes that will occur with insurance and health care under the Affordable Care Act (ACA). Many are looking forward to having access to health care insurance, while others are concerned about how health care reform will affect their benefits and budgets. And there are many Americans who are not aware that changes are coming.

A recent Kaiser Family Foundation poll discovered that 52 percent of respondents did not know the ACA was a law. Of this group, 12 percent thought Congress eliminated it, 7 percent believed the U.S. Supreme Court got rid of it, and 23 percent did not know whether or not the law existed.

Even though reform is featured regularly in the news, nearly half of the people polled said they did not have enough information to know whether the law will impact their lives. Most were less concerned about how the ACA will affect people across the country and were more focused on the impact on their paycheck and budget.

There are many misconceptions about the ACA, especially how it relates to dental and vision coverage. While medical coverage impacts are confusing, dental and vision are easier to understand. Brokers and insurance consultants can provide employers with reliable information they can use to educate employees about the effect of reform on their dental and vision benefits. Here are several common areas of misunderstanding:

Stand-Alone Dental and Vision Plans

According to the National Association of Dental Plans, 98 percent of dental benefits are provided through stand-alone dental policies for individuals or families, independent of a medical plan. Under the ACA, dental and vision benefits sold in stand-alone policies are not subject to most provisions. Only pediatric dental and vision benefits are part of Essential Health Benefit Packages (EHBPs), which are required to be offered to most individuals and small employers, unless their medical plans are grandfathered.

For brokers and consultants, this means that stand-alone dental plans are not subject to market reforms, such as the minimum loss ratio, providing an advantage in retaining and expanding business with employers.

Many Employers Can Keep Same Benefits

In the ACA, employers are not required to purchase any health coverage for employees and their dependents through a health insurance exchange, which means they may keep their current medical, dental and vision benefits with the same insurance carriers.

However, employers with 50 or more employees must offer Minimum Essential Coverage that is affordable and meaningful or pay a fine. But this does not include dental or vision.

As a note of caution, individual consumers choosing not to purchase health benefits may be assessed a small penalty, but it is not clear whether that extends to the purchase of pediatric dental or vision benefits in the small-group market.

Understanding Pediatric Essential Benefits

Under the ACA, there are 10 Essential Health Benefits (EHBs) that must be offered to most individuals and small groups both inside and outside marketplace exchanges, unless the medical plan is grandfathered. One of these EHBs is pediatric dental and vision benefits, which will be offered within state insurance exchanges and to most small employers outside the exchanges.

Medical coverage offered within an exchange must include a pediatric vision and dental benefit. If the same exchange offers a stand-alone dental plan providing the required pediatric dental benefit, the medical plan has the option to exclude that benefit.

In an exchange marketplace, medical plans with dental or vision coverage likely will cover only children. This means that adults who purchase pediatric dental and vision coverage for dependents will need to purchase these benefits separately to maintain their own health. Adults and dependents purchasing dental or vision through an exchange or EHBP could then have different benefit plans than their children.

Here are a few other key points:

- When the pediatric dental benefit is offered in an exchange on a stand-alone basis, employers and individuals are not required to purchase it (by federal law, but a few states may say otherwise).
- Costs for services from a dentist outside a particular exchange plan's network will not apply to a limit on the amount of out-of-pocket costs an insured pediatric member is required to assume before the plan pays in full for covered services.
- Traditional pediatric orthodontia coverage may not be available in state exchanges or EHBPs. Currently only orthodontia declared medically necessary (for example, coverage related to a cleft palate condition) would be covered as an EHB. Children undergoing a traditional orthodontia treatment program that extends beyond 2013 may be impacted significantly if their coverage is moved to an EHB or exchange. Some plans may offer additional wrap-around options with pediatric orthodontia coverage, but benefits and providers may differ from existing plans.

Benefit selections within an exchange will be limited to set plan designs and selected insurance carriers. Employers will not be able to customize plans.

Combined Plans May Not Provide Expected Benefits

Exchange marketplaces may offer medical plans combined with dental and or vision coverage. While a medical plan offering dental coverage may seem cheaper (one premium), it likely will have a large combined deductible, and nonpreventive dental expenses may not be covered until the medical deductible is satisfied. The high out-of-pocket maximum for medical likely will have to be met before covered pediatric dental or vision would be paid in full by the plan. It's important for brokers and consultants to note that, in this scenario, the dental premium is included in the minimum loss ratio calculation.

Tax Credits and Subsidies

There have been numerous discussions about tax credits and subsidies that employers and individuals may receive under the ACA. It is important to note that only certain employers with fewer than 25 employees may receive tax credits for medical coverage. This credit is available only when purchasing within an exchange until 2015. And only individuals who purchase benefits through the public individual exchange can obtain advance premium tax credits to help with premiums. This subsidy will be applied to the medical coverage first and probably will not be large enough to cover stand-alone dental benefit costs.

Reviewing Marketplace Plans

Employers and individuals exploring dental or vision benefit options through a state exchange or private marketplace should review the plan designs carefully to understand the coverage they will receive.

Plans offered in an exchange may not be cheaper than those offered by an insurance carrier in a private market. Premiums probably will be based on limited criteria instead of utilization trends within an employer's industry or claim experience. Since insurance carriers will be charged by state and federal governments to participate in exchanges, these fees likely will be included in the premium costs.

Due to recent changes in federal rules, small employers offering coverage through most exchanges may select only one plan in 2014 for their employees, rather than the "employee choice" model originally anticipated. Individuals purchasing individual or small-group dental coverage, either in or outside an exchange, need to know they may have to change dentists if their current one does not participate in the plan.

Brokers and consultants can assist employees seeking additional or separate coverage from their employer's plan by helping them understand what procedures the plans cover. They also should look for benefits that properly supplement employer plans to avoid losing overall coverage.

When evaluating marketplace plan options, use these guidelines:

- Identify covered dental or vision services, copayments and reimbursement percentage levels.
- Know the deductible that must be met before nonpreventive services are covered.
- Review the network to see whether changes in providers may be needed.
- Understand whether there is a waiting period that must be met before using the benefits.
- Know whether there are exclusions or conditions for coverage.
- Know whether the out-of-pocket maximum applies separately to dental or if the medical out of pocket applies.

Health care reform dictates new directions for health benefits, but the needs of Americans have not changed. Dental and vision services are essential for good health at any age.

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