



November 2, 2010

Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Room N-5653
U.S. Department of Labor
200 Constitution Avenue, NW
Washington, DC 20210

Office of Consumer Information and Insurance Oversight
U.S. Department of Health and Human Services
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

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Internal Revenue Service
1111 Constitution Avenue, NW
Washington, DC 20224

Re: Clarification of Limited Scope Dental and Vision “Excepted Benefits” Test

To Whom It May Concern:

We are writing to request clarification about when limited scope dental and vision benefits are “offered separately” and therefore are "excepted benefits" pursuant to PHSA Sec 2791(c)(2)(A).

Stand-alone dental and vision benefit carriers separately contract with employers and unions to provide dental-only and vision-only coverage to millions of employees and their families. Historically, their role has been to insure this coverage as well as to offer provider networks, claims processing systems and plan administration designed specifically for these benefits.

More recently, the larger employers and unions still rely on stand-alone dental and vision carriers for provider networks, claims processing and plan administration, but now predominantly self-insure their separate dental and vision coverage.

This trend to self-insurance among these purchasers has led to uncertainty about whether the dental and vision benefit programs that are separately administered for them are “excepted benefits.” That uncertainty has gained more relevance with the passage of the Patient Protection and Affordable Care Act, which imposes a number of "market reform" requirements on group health plans and group health insurance, however, with continued exception for "excepted benefits.”

As you know, the statutory and regulatory definitions of “excepted benefits” were adopted in 1996, as a part of HIPAA, and generally provide that limited scope dental benefits are not subject to requirements that are otherwise imposed on major medical group health plans and health insurance if the dental benefits are “offered separately.”

A special rule for limited scope dental and vision benefits provided in connection with a “group health plan” provides that limited scope dental benefits are an “excepted benefit” if such benefits: (i) “are provided under a separate policy, certificate, or contract of insurance,” or (ii) “are otherwise not an integral part of the plan.”

Thus, dental and vision benefits are *per se* “offered separately” if provided by virtue of a separate underlying policy, certificate, or contract for the benefit. If there is not a separate policy, certificate, or contract, an employer or union may yet demonstrate that the dental or vision benefit is “otherwise not an integral part” of its group health plan, and as a result, have “excepted benefit” status.

According to the regulations, this can be shown only if participants have the right not to elect this coverage and must pay an additional premium for it. The “not an integral part” test thus comes into play when the underlying contract for a group health plan “bundles” dental or vision together with major medical benefits – i.e. where the dental benefit is not separately contracted and so the “separate” nature of the dental or vision benefit is not readily apparent.

The uncertainty we hear from employer sponsors of self-insured dental and vision benefit programs who separately contract with dental or vision plans arises from the statutory phrase cited above – i.e. “a separate policy, certificate, or contract of *insurance*” [emphasis added]. These programs, established by separate administrative-only contracts, are clearly no more “bundled” than if they were based on separate *insurance* contracts.

Moreover, dental and vision benefit companies administer these programs separately from the sponsors’ medical benefits. Nevertheless, some of these purchasers are concerned that they must meet the “not an integral part” test simply because they have technically not entered into contracts of *insurance*, even though they are contracting with licensed carriers to separately administer the benefit.

For these purchasers, requiring that their participants must be able to not elect dental or vision coverage and must pay an additional premium makes no more sense than if they had purchased separately contracted *insured* programs.

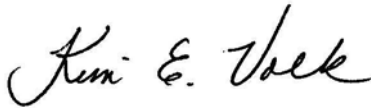
In an August 27, 2010, joint comment letter on the Interim Final Rule on “Annual and Lifetime Limits” from the American Benefits Council and the HR Policy Association, these groups stated: “Employers, particularly those participating in multi-employer plans, often provide dental and vision benefits at no cost without a separate election required (since coverage is provided automatically). We also recommend that the regulation be revised to allow employer-pay-all benefits also to be considered ‘not an integral part of the plan’ where offered separately.”

We strongly support the goal of permitting employer-pay-all dental-only and vision-only benefits to be an “excepted benefit” where offered separately.

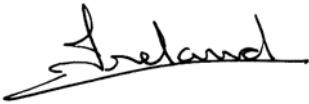
We also request guidance and regulatory clarification with respect to the phrase “separate policy, certificate, or contract of insurance” to include administrative services dental-only and vision-only contracts issued by licensed carriers that enable employers to provide these benefits on a self-insured basis. This is because administrative services contracts for dental-only and vision-only benefits are *separate* from contracts for the administration of medical benefits provided by group health plans.

We very much appreciate your consideration of this request. Please feel free to call us or our staffs if you have any questions or comments.

Sincerely,



Kim Volk
President & CEO
Delta Dental Plans Association



Evelyn Ireland
President & CEO
National Association of Dental Plans



J. Robinson Lynch
President & CEO
VSP Vision Care