MEMORANDUM

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SUBJECT Application of Certain Provisions of the Patient Protection and Affordable Care Act to Limited Scope Benefits

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Background

When Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996 the Group Market Reforms in Part A and Individual Market Rules in Part B of Title XXVII of the Public Health Service Act (PHSA) were applied to comprehensive, major medical health plans and health insurance coverage. Supplemental health insurance products, defined as "excepted benefits," were explicitly exempted from these provisions. The definition of "excepted benefits" includes limited scope dental and vision benefits offered separately.

The Patient Protection and Affordable Care Act (PPACA)[1] amends the PHSA to establish new requirements for group health plans and health insurance issuers operating in the individual and group health insurance markets. PPACA adds several new sections to Part A of Title XXVII of the PHSA, amends and renumbers existing sections, and changes the subpart headings within Part A. PPACA also amends the Internal Revenue Code of 1986 (Code) and the Employee Retirement Income Security Act of 1974 (ERISA) to incorporate all of the requirements of Part A by cross-reference (rather than simply making parallel changes to those laws, as is done under current law).

Issue

Separate provisions are applied to pediatric dental benefits that are allowed to be offered separately inside the Exchanges beginning in 2014. Other than those pediatric dental benefits, how do the changes made by PPACA to Part A of Title XXVII of the PHSA (and the Code and ERISA) affect limited scope benefits, such as separate dental and vision benefits?

Conclusion

Limited scope benefits, such as separate dental and vision benefits, should continue to be excluded from the requirements that apply to other group health plans and products under Part A (and the Code and ERISA) in the same way they are under current law.

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[1] Pub. L. No. 111-148.

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Analysis

1. Limited Scope Dental and Vision Benefits Currently Are Exempt from the Substantive Requirements of Title XXVII of the PHSA and Parallel Requirements in ERISA and the Code

Part A of Title XXVII of the PHSA[2] currently contains provisions relating to coverage and benefits under group insurance policies and employment-based group health plans. There are parallel provisions in ERISA[3] and the Code.[4] Part B of Title XXVII of the PHSA[5] contains similar provisions relating to coverage and benefits under individual insurance policies. Separate dental and vision plans never have been subject to these provisions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA),[6] which enacted many of these provisions, expressly exempted plans and policies with respect to "[l]imited scope dental or vision benefits" that are provided under a "separate policy, certificate, or contract of insurance," or, in the case of a group health plan, "are otherwise not an integral part of the plan."[7]

The current organization of Parts A and B of Title XXVII of the PHSA is shown in Appendix A. As can be seen, Part A has four subparts. The substantive requirements for group insurance policies and group health plans are in Subparts 1-3. Subpart 4 contains non-substantive rules, including PHSA § 2721,[8] which exempts separate dental and vision plans from the requirements of Subparts 1-3.[9] Part B of Title XXVII of the PHSA has a similar structure, except that it has only three subparts. Subpart 3 contains the non-substantive rules, including PHSA § 2763,[10] which exempts separate dental and vision plans from the requirements of Part B.

2. Limited Scope Dental and Vision Benefits Should Continue to be Exempt from the Substantive Requirements of Title XXVII of the PHSA and Parallel Requirements in ERISA and the Code

The new organization of Parts A and B of Title XXVII of the PHSA is shown in Appendix B. Part A now will have only two substantive subparts—Subparts I and II—and PHSA § 2721 will be renumbered as PHSA § 2722. Generally speaking, the provisions in Subparts 1 and 3 of current Part A will be in new Subpart I, along with several new provisions and only after being amended significantly. Further, the provisions in Subpart 2 of current Part A will be in new Subpart II, along with several new provisions.

Consistent with this new structure, PPACA § 1563(a)[11] (labeled "Applicability") amends PHSA

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[2] 42 U.S.C. Chapter 6A, Subchapter XXV, Part A.
[3] 29 U.S.C. Chapter 18, Subchapter I, Subtitle B, Part 7.
[4] 26 U.S.C. Subtitle K, Chapter 100.
[5] 42 U.S.C. Chapter 6A, Subchapter XXV, Part B.
[6] Pub. L. No. 104 191.
[7] PHSA § 2721(d)(1), 42 U.S.C. § 300gg-21.
[8] Id.
[9] Similarly, ERISA § 732, 29 U.S.C. § 1191a, and Code § 9831, 29 U.S.C. § 9831, exempt separate dental and vision plans from the parallel substantive requirements in those statutes.
[10] 42 U.S.C. § 300gg-63.
[11] PPACA § 1562 was renumbered as PPACA § 1563 by PPACA § 10107(b).

§ 2721 (now PHSA § 2722)[12] to exempt such plans from Subparts 1 and 2 (an apparent reference to Subparts I and II) of new Part A. Neither the structure of Part B, nor the structure of the provisions in ERISA and the Code that parallel Part A, were changed at all.[13]

PPACA § 1563(c)(12) (in a subsection labeled "Technical and Conforming Amendments") also amends PHSA § 2721 (now PHSA § 2722) in a way that almost entirely duplicates PPACA § 1563(a)[14] but references only Subpart 1 of Part A. This reference change could result in a reading of the language in PPACA § 1563(c)(12) to the effect that separate dental and vision plans now will be exempt only from Subpart I, and not Subpart II, of Part A. This is not the most appropriate reading of PPACA, however: It would be inconsistent with the long-standing treatment of such plans under HIPAA. It would subject them not only to a number of new provisions added by PPACA, but also to existing requirements from which they currently are exempt. Many of these requirements would make no sense as applied to dental and vision plans, including requirements relating to hospital stays following delivery and required reconstructive surgery following mastectomies. Such an extension also would be inconsistent with Part B and the provisions in ERISA and the Code that parallel Part A, the structures of which, as noted above, continue to exempt such plans from individual and group insurance requirements, respectively.

The better reading of PPACA is that an unintended technical error was made in the combination of Senate bills that became PPACA. PPACA § 1563(c)(12) is virtually identical to section 133(a)(12) of S. 1679, the Senate Health, Education, Labor, and Pensions (HELP) Committee's health reform bill. There the reference solely to Subpart 1 made sense, because section 133(a)(2) & (a)(7) of S. 1679 had consolidated Subparts 2 and 3 of Part A into Subpart 1, leaving Subpart 1 as the only remaining substantive subpart in Part A. By contrast, in the PHSA as amended by PPACA this no longer makes sense, since, as explained above, PPACA leaves two—not one—substantive subparts in Part A. Further evidence that these amendments were imported into PPACA without sufficient attention to the other changes in PPACA is that PPACA § 1563(c)(11)—just like section 133(a)(11) of S. 1679—redesignates Subpart 4 of Part A as Subpart 2. Again, this made sense in S. 1679, which had consolidated all of the substantive subparts of Part A into Subpart 1, but no longer makes sense under PPACA, which consolidated the substantive subparts of Part A into Subparts I and II.

PPACA § 1563(c)(12) should be interpreted in a manner that is consistent with PPACA § 1563(a), namely as preserving the current and long-standing statutory structure and exempting separate dental and vision plans from the substantive requirements of Part A (and the parallel provisions of ERISA and the Code). Alternatively, the portions of PPACA § 1563(c)(12) that duplicate PPACA § 1563(a)—which would include all except the renumbering of the exception as PHSA § 2722 and redesignating subsections (b) through (e) as (a) through (d)—should be disregarded as unnecessary

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[12] Also, at the point in PPACA where these amendments appear, PHSA § 2721 had temporarily been renumbered as PHSA § 2735, and was only somewhat later renumbered as PHSA § 2722. Since that renumbering was only temporary, we disregard it in this memorandum.

[13] Cf. PHSA § 2762(c), ERISA § 715(a), and Code § 9815(a), as added by PPACA § 1563(c)(15), (e) and (f) (importing Part A rules).

[14] The only additional amendment that PPACA § 1563(c)(12) makes is to renumber PHSA § 2721 as PHSA § 2722.

(and erroneous) surplus language.[15]

3. Summary

In conclusion, PPACA should be interpreted as continuing to exempt separate dental and vision plans from the substantive requirements under Part A of Title XXVII of the PHSA, and the parallel provisions of ERISA and the Code, just as they were prior to enactment of PPACA. It appears that a drafting error occurred, which can be explained by examining the legislative history of health reform legislation. We believe it is clear that Congress intended to continue the exemption of limited scope dental and vision benefits provided under a separate policy or plan.

[15] See, e.g., U.S. v. Coatoam, 245 F.3d 553, 557-58 (6th Cir.), cert. denied, 122 S. Ct. 280 (2001) (drafting error in cross-reference disregarded where it produced absurd result; structure of statute may be used to discern Congressional intent).

Appendix A

Current Organization of Parts A and B of PHSA Title XXVII

Part A—Group Market Reforms

- Subpart 1—Portability, Access, and Renewability Requirements
  - Sec. 2701. Increased portability through limitation on preexisting condition exclusions
  - Sec. 2702. Prohibiting discrimination against individual participants and beneficiaries based on health status
- Subpart 2—Other Requirements
  - Sec. 2704. Standards relating to benefits for mothers and newborns
  - Sec. 2705. Parity in mental health and substance use disorder benefits
  - Sec. 2706. Required coverage for reconstructive surgery following mastectomies
  - Sec. 2707. Coverage of dependent students on medically necessary leave of absence
- Subpart 3—Provisions Applicable Only to Health Insurance Issuers
  - Sec. 2711. Guaranteed availability of coverage for employers in the group market
  - Sec. 2712. Guaranteed renewability of coverage for employers in the group market
  - Sec. 2713. Disclosure of information
- Subpart 4—Exclusion of Plans; Enforcement; Preemption
  - Sec. 2721. Exclusion of certain plans
  - Sec. 2722. Enforcement
  - Sec. 2723. Preemption; state flexibility; construction

Part B—Individual Market Rules

- Subpart 1—Portability, Access, and Renewability Requirements
  - Sec. 2741. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage
  - Sec. 2742. Guaranteed renewability of individual health insurance coverage
  - Sec. 2743. Certification of coverage
  - Sec. 2744. State flexibility in individual market reforms
  - Sec. 2745. Relief for high risk pools
- Subpart 2—Other Requirements
  - Sec. 2751. Standards relating to benefits for mothers and newborns
  - Sec. 2752. Required coverage for reconstructive surgery following mastectomies
  - Sec. 2753. Prohibition of health discrimination on the basis of genetic information
  - Sec. 2754. Coverage of dependent students on medically necessary leave of absence
- Subpart 3—General Provisions
  - Sec. 2761. Enforcement
  - Sec. 2762. Preemption
  - Sec. 2763. General exceptions

Appendix B

New Organization of Parts A and B of PHSA Title XXVII

Part A—Individual and Group Market Reforms

Subpart I—General Reform

Sec. 2701. Fair health insurance premiums
Sec. 2702. Guaranteed availability of coverage
Sec. 2703. Guaranteed renewability of coverage
Sec. 2704. Prohibition of preexisting condition exclusions or other discrimination based on health status
Sec. 2705. Prohibiting discrimination against individual participants and beneficiaries based on health status
Sec. 2706. Non-discrimination in health care
Sec. 2707. Comprehensive health insurance coverage
Sec. 2708. Prohibition on excessive waiting periods
Sec. 2709. Disclosure of information
Sec. 2709. Coverage for individuals participating in approved clinical trials.[16]

Subpart II—Improving Coverage

Sec. 2711. No lifetime or annual limits
Sec. 2712. Prohibition on rescissions
Sec. 2713. Coverage of preventive health services
Sec. 2714. Extension of dependent coverage
Sec. 2715. Development and utilization of uniform explanation of coverage documents and standardized definitions
Sec. 2715A. Provision of additional information
Sec. 2716. Prohibition of discrimination in favor of highly compensated individuals
Sec. 2717. Ensuring the quality of care
Sec. 2718. Bringing down the cost of health care coverage
Sec. 2719. Appeals process
Sec. 2719A. Patient protections
Sec. 2725. Standards relating to benefits for mothers and newborns
Sec. 2726. Parity in mental health and substance use disorder benefits
Sec. 2727. Required coverage for reconstructive surgery following mastectomies
Sec. 2728. Coverage of dependent students on medically necessary leave of absence

Subpart 2—Exclusion of Plans; Enforcement; Preemption

Sec. 2722. Exclusion of certain plans[17]
Sec. 2723. Enforcement
Sec. 2724. Preemption; state flexibility; construction

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[16] The designation of two sections as PHSA § 2709 appears to be a drafting error.

[17] PHSA §§ 2721-2723 were renumbered twice in the Act, first as PHSA §§ 2735-2737, and second as PHSA §§ 2722-2724, but the Act does not indicate that these sections should be moved to precede PHSA § 2725 in Subpart II. It appears that Congress intended for these sections to be out of numerical order with the rest of Part A. Had these sections been moved, there would be no text left in the former Subpart 4 (redesignated as Subpart 2).

Part B—Individual Market Rules
Subpart 1—Portability, Access, and Renewability Requirements
Sec. 2741. Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage
Sec. 2742. Guaranteed renewability of individual health insurance coverage
Sec. 2743. Certification of coverage
Sec. 2744. State flexibility in individual market reforms
Sec. 2745. Relief for high risk pools
Subpart 2—Other Requirements
Sec. 2751. Standards relating to benefits for mothers and newborns
Sec. 2752. Required coverage for reconstructive surgery following mastectomies
Sec. 2753. Prohibition of health discrimination on the basis of genetic information
Sec. 2754. Coverage of dependent students on medically necessary leave of absence
Subpart 3—General Provisions
Sec. 2761. Enforcement
Sec. 2762. Preemption
Sec. 2763. General exceptions