



Enforcement of Private Health Insurance Market Reforms Under the Affordable Care Act (PPACA)

Jennifer Staman
Legislative Attorney

January 12, 2012

Congressional Research Service

7-5700

www.crs.gov

R41624

Summary

The Patient Protection and Affordable Care Act (PPACA or ACA), as amended to date, greatly expanded the scope of federal regulation over health insurance provided through employment-based group health coverage, as well as coverage sold in the individual insurance market. Federal health insurance standards created by ACA require an extension of dependent coverage to age 26 if such coverage is offered; the elimination of preexisting condition exclusions; a bar on lifetime annual limits on the dollar value of certain benefits; a prohibition on health insurance rescissions except under limited circumstances; and coverage of preventive health services without cost-sharing, among many other things. While some of these changes took effect in 2010, others are scheduled to begin in 2014. ACA does not expressly include any means for enforcing these new health insurance standards, although these new standards were added to Title XXVII of the Public Health Service Act (PHSA), and incorporated by reference into Part 7 of the Employee Retirement Income Security Act (ERISA) and Chapter 100 of the Internal Revenue Code (IRC). However, if these standards are not followed, enforcement may be carried out through mechanisms (such as judicial review and other penalties) that existed prior to ACA in these three federal statutes.

The IRC, the PHSA, and ERISA apply to different types of private health insurance coverage and contain different types of enforcement mechanisms. ERISA applies to group health coverage provided by private-sector employers. Section 502(a) of ERISA authorizes various civil actions that may be brought by a participant or beneficiary of a plan against both group health plans and health insurers. In general, the private health insurance requirements of Title XXVII of the PHSA apply to health insurers offering group and individual health coverage, as well as health plans offered to government employees. With respect to health insurers, the PHSA allows states to be the primary enforcers of the private health insurance requirements, but the Secretary of Health and Human Services (HHS) assumes responsibility for enforcing them with respect to governmental plans. Chapter 100 of the IRC applies to group health coverage, and the Department of Treasury can enforce the health plan requirements through the imposition of an excise tax. This report examines these provisions in ERISA, the PHSA, and the IRC that could be used to enforce new ACA health insurance standards.

In addition, ACA provides that, beginning in 2014, each state, or if a state fails to do so, the Secretary of HHS, must establish at least one American Health Benefit Exchange that facilitates the purchase of individual and group health insurance plans from insurers. ACA's new federal health insurance standards appear to apply to health insurers both inside and outside an exchange. However, insurers that offer coverage through an exchange will be subject to additional requirements. This report will also briefly address enforcement of health coverage offered through an exchange.

Contents

Introduction.....	1
Background on State and Federal Health Insurance Regulation.....	2
Enforcement of Relevant ACA Provisions in ERISA, the PHSA, and the IRC	5
ERISA	5
The PHSA.....	7
The IRC	8
Enforcement of Relevant ACA Provisions in Health Coverage Provided Under a Health Insurance Exchange	9

Tables

Table 1. Private Health Insurance Requirements in the IRC, the PHSA, and ERISA	9
--	---

Contacts

Author Contact Information.....	10
---------------------------------	----

Introduction

According to census data, in 2010, approximately 64% of individuals in the United States were covered by a form of private health insurance provided either through an employer or a union, or purchased by an individual from a private company.¹ While states traditionally have been the principal regulators of health insurance, since the 1970s the federal government has become increasingly involved. The Patient Protection and Affordable Care Act (ACA), as amended, greatly expanded federal regulation of health insurance by adding a number of health insurance reforms designed to increase access to private health insurance for individuals and enhance the delivery and quality of health care.²

ACA sets new minimum standards for private health insurance coverage, including an extension of dependent coverage to age 26; the elimination of preexisting condition exclusions; a bar on lifetime and certain annual benefit limits; a prohibition on health insurance rescissions except under limited circumstances; and coverage of preventive health services without cost sharing, among many other things.³ These requirements may apply to group health plans, broadly defined as plans established or maintained by an employer that provides medical care.⁴ Group health plans can be insured (i.e., purchased from an insurance carrier) or self-insured (funded directly by the employer).⁵ ACA's requirements may also apply to "health insurance issuers," health insurers that issue a policy or contract to provide group or individual health insurance coverage.⁶ In general, Title I of ACA does not expressly contain enforcement tools, such as judicial review or penalties, that may be imposed for violating the new private health insurance requirements.⁷ However, since ACA amends three preexisting statutes—the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code

¹ See U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2010* at 23.

² P.L. 111-148 (2010), §§ 1001-104, 1201-1255. ACA was amended by the Health Care Education and Reconciliation Act of 2010, P.L. 111-152 (2010). (HCERA). These acts will be collectively referred to in this report as "ACA."

³ For a discussion of these new ACA requirements, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

⁴ 42 U.S.C. § 300gg-91(a)(1).

⁵ Under self-insured (or self-funded) plans, an employer acts as the insurer itself and pays the health care claims of the plan participants. While self-insured plans may use an insurance company or other third party to administer the plan, the employer bears the risk associated with providing health coverage. For more information on self-insured health plans, see CRS Report R41069, *Self-Insured Health Insurance Coverage*, by Bernadette Fernandez.

It should be noted that the distinction between fully insured and self-insured plans matters for regulatory purposes because of the express preemption provision of ERISA. Section 514(a) of ERISA preempts state laws that "relate to" an employee benefit plan. 29 U.S.C. § 1144(a). However, ERISA sets out certain exceptions to the preemption provision, including an exemption for state laws that regulate insurance. 29 U.S.C. § 1144(b). Thus, health benefits offered through health insurance (i.e., where an employer pays a premium to an insurer to cover the claims of plan participants) may be subject to state regulation. Self-insured plans, under which an employer provides health benefits directly to plan participants, are not exempt from ERISA's preemption provisions and are, therefore, not subject to state law.

⁶ A health insurance issuer is defined as an insurance company, insurance service, or insurance organization that is licensed to engage in the business of insurance in a state and which is subject to state law that regulates insurance. 42 U.S.C. § 300gg-91(b)(2).

⁷ However, one exception is Section 2715(f) of the Public Health Service Act, created by Section 1001 of ACA, which provides that if health insurance issuers and certain group health plans willfully fail to provide a summary of benefits and coverage as required by the section, they will be subject to a fine of not more than \$1,000 for each failure. See 42 U.S.C. § 300gg-15(f)(2).

(IRC)—enforcement under federal law may be carried out through mechanisms in those statutes.⁸ This report examines these selected federal mechanisms.⁹

In addition, ACA provides that, beginning in 2014, each state, or if a state fails to do so, the Secretary of Health and Human Services (HHS), must establish at least one American Health Benefit Exchange that facilitates the purchase of individual and group health insurance plans from insurers.¹⁰ ACA's new federal health insurance standards appear to apply to health insurers both inside and outside an exchange.¹¹ However, insurers that offer coverage through an exchange will be subject to additional requirements. This report will briefly address enforcement of health coverage offered through an exchange.¹²

Background on State and Federal Health Insurance Regulation

In order to examine how ACA's private health insurance requirements will be enforced, it is helpful to understand the basic landscape of federal private health insurance regulation. Traditionally, health insurance matters were primarily regulated at the state, rather than the federal, level. Accordingly, states can and do regulate health insurance comprehensively. Every state has requirements related to the finances, management, and business practices of insurers. These requirements vary from state to state, but many states require insurers, for example, to be financially solvent and to pay claims promptly, and to mandate certain benefits (i.e., require health insurers to cover services provided by certain medical specialties or cover treatments for specific diseases).

Congress explicitly recognized the role of the states in the regulation of insurance with the passage of the McCarran-Ferguson Act of 1945. This law was passed in response to the Supreme Court's ruling in *United States v. South-Eastern Underwriters*,¹³ in which the Court affirmed the federal government's right to regulate the competitive practices of insurers under the Commerce Clause of the U.S. Constitution. The intent of the McCarran-Ferguson Act was to grant states the explicit authority to regulate insurance in light of this decision. Section 2(a) of the act states, "The

⁸ Besides the creation of new private health insurance standards, Title I of ACA contains a number of additional requirements that affect individuals and employers. For example, ACA contains an "individual responsibility requirement," a provision compelling certain individuals to have a minimum level of health insurance (i.e., an "individual mandate"). Individuals who fail to do so are subject to a monetary penalty, administered through the tax code. In addition, under ACA, certain large employers may be subject to a tax penalty if they do not offer coverage, or they offer coverage that does not meet certain affordability criteria. This report only addresses enforcement of the new minimum standards for private health insurance coverage set out primarily in Sections 1001 and 1201 of ACA.

⁹ It should be noted that Section 1001 of ACA added Section 2718 of the PHSA, which provides for appeals of coverage determinations and claims. While these administrative processes may be seen as a way to enforce benefit rights, this report will focus on legal enforcement and remedies available under federal statutes.

¹⁰ P.L. 111-148, § 1301 et seq.

¹¹ See, e.g., Department of Health and Human Services, Initial Guidance to States on Exchanges (Nov. 18, 2010), <http://www.healthcare.gov/law/resources/regulations/guidance-to-states-on-exchanges.html>.

¹² It should be noted that a number of bills have been introduced that would repeal or significantly amend ACA. See, e.g., H.R. 2, 112th Cong. (2011). In addition, several lawsuits have been filed that challenge provisions of ACA on constitutional grounds. For a discussion of these lawsuits, see CRS Report R40725, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, by Jennifer Staman et al. This report analyzes ACA in its current form.

¹³ 322 U.S. 533 (1944).

business of insurance, and every person engaged therein, shall be subject to the laws of the several States which relate to the regulation or taxation of such business.”¹⁴ However, under the act, Congress also reserved to itself the right to enact federal statutes that specifically relate to “the business of insurance.”¹⁵ Pursuant to this right, Congress has passed legislation which regulates insurance in particular instances.

In the 1970s, the federal government enacted ERISA to regulate private-sector employee benefit plans. Besides pension plans, ERISA also regulates welfare benefit plans¹⁶ offered by an employer to provide medical, surgical, and other health benefits. Like other non-pension plans governed by ERISA, health plans must comply with fiduciary standards, reporting and disclosure requirements, and procedures for appealing a denied claim for benefits.

ERISA also contains an express preemption provision, Section 514, which preempts state laws that “relate to” an employee benefit plan.¹⁷ However, one exception to the preemption provision is an exemption for state laws that regulate insurance.¹⁸ Accordingly, a group health plan that provides health benefits through an insurance company can be regulated by state insurance law, as well as by ERISA. On the other hand, a plan that is self-insured is only subject to ERISA’s requirements and is immune from additional regulation at the state level.¹⁹

In 1996, Congress passed one of the most comprehensive federal acts affecting private health insurance, the Health Insurance Portability and Accountability Act (HIPAA), which established minimum national standards for private health insurance.²⁰ The basic intent of HIPAA’s health insurance provisions was to reduce the possibility that individuals and certain employers would lose existing health plan coverage, and to make it easier for individuals to maintain coverage when changing jobs or to purchase coverage on their own if they lose employer-offered coverage.²¹ Under HIPAA, group health plans and health insurance issuers that provided group health coverage were subject to limitations on the period of time that an individual could be excluded from coverage because of a preexisting condition. The act also prohibited plans and issuers in the group health insurance market from discriminating against individuals in terms of

¹⁴ 15 U.S.C. § 1012(a).

¹⁵ 15 U.S.C. § 1012(b).

¹⁶ ERISA considers a number of non-pension benefit programs offered by an employer to be “employee welfare benefit plans.” For example, health plans, life insurance plans, and plans that provide dependent care assistance, educational assistance, or legal assistance can all be deemed welfare benefit plans. *See* 29 U.S.C. § 1002(1).

¹⁷ 29 U.S.C. § 1144(a).

¹⁸ 29 U.S.C. § 1144(b).

¹⁹ It should be noted ACA contains requirements that appear to create a role for states with respect to self-insured plans. For example, under Section 2715A of the PHSA, group health plans, including self-insured plans, must make certain disclosures, such as financial disclosures and disclosures on enrollment to the Secretary, as well as the state insurance commissioner.

²⁰ P.L. 104-191, 110 Stat. 1936 (1996).

²¹ HIPAA’s provisions addressing insurers in the individual market were different from the group health plan provisions, in that the act left more of the individual market regulation to the states. For example, under HIPAA, insurers in the individual market that provided coverage to certain eligible individuals who were previously enrolled in group coverage for at least 12 months were prohibited from imposing preexisting condition exclusions on these individuals. However, states could choose to adopt an alternative mechanism (in accordance with certain federal standards) in lieu of adopting the federal requirements. For individuals who were not eligible, insurers could refuse to provide coverage, or impose a preexisting condition exclusion, in compliance with state law.

eligibility for coverage, enrollment, premiums, or other contributions based on certain health-related factors, such as medical history or disability.²²

The group health coverage requirements of HIPAA were set out as substantively similar provisions in three federal statutes: ERISA, the PHSa, and the IRC.²³ These three statutes apply to different types of private health insurance coverage and contain different types of enforcement mechanisms. Following enactment of HIPAA, Congress enacted other statutes that mirrored the three-statute regulatory model. These include the Newborns' and Mothers' Health Protection Act,²⁴ which sets standards for benefits provided to mothers and newborns following childbirth; the Mental Health Parity Act of 1996, providing for parity between medical/surgical benefits and mental health benefits;²⁵ the Women's Health and Cancer Rights Act,²⁶ requiring group health plans providing mastectomy coverage to cover prosthetic devices and reconstructive surgery; and Michelle's Law,²⁷ which extends the ability of dependents to remain on their parents' plan for a limited period of time during a medical leave from full-time student status.²⁸ These federal insurance standards created by HIPAA and subsequent acts were intended to act as a federal "floor," while preserving the states' role in regulating health insurance. ERISA and the PHSa specify that the federal health insurance requirements as applied to health insurance issuers do not supersede state law, except to the extent that a state law "prevents the application" of a federal requirement.²⁹ Thus, states are allowed to regulate health insurance more comprehensively than federal law, so long as these requirements do not conflict with federal standards.

ACA significantly amended and expanded upon these federal health insurance standards, adding several new requirements for group health plans and health insurance issuers in the group and individual markets. Title I of ACA amended the PHSa, and these provisions are incorporated by reference into ERISA and the IRC.³⁰ Section 1563 of ACA provides that the new PHSa requirements apply to group health plans, and health insurance issuers providing health insurance coverage under ERISA and the IRC as if they were included in the statutes; and to the extent that a provision of those statutes conflicts with a provision added by ACA, the provisions of ACA apply.³¹ Because ACA health insurance standards are incorporated by reference into ERISA and the IRC, the enforcement mechanisms of these two laws may be applied.

²² See, e.g., 29 U.S.C. § 1182(a)(1)(A)-(H).

²³ It should be noted that HIPAA was not the first act to use this three statute regulatory model. The Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, P.L. 99-272, tit. X, 100 Stat. 327 (1986), amends ERISA, the PHSa, and the IRC to require the sponsor of a group health plan to provide plan participants and beneficiaries the option of temporarily continuing health care coverage under certain circumstances.

²⁴ P.L. 104-204, tit. VI, 110 Stat. 2935 (1996).

²⁵ Mental health parity was changed in other legislation. For a discussion of mental health parity, see CRS Report R41249, *Mental Health Parity and the Patient Protection and Affordable Care Act of 2010*, by Amanda K. Sarata.

²⁶ P.L. 105-277, 112 Stat. 2681 (1998).

²⁷ P.L. 110-381, 122 Stat. 4086 (2008).

²⁸ It should be noted that these laws, either as enacted or following the enactment of ACA, apply to health insurance issuers providing coverage in the individual market. See 42 U.S.C. § 300gg-25 et seq.

²⁹ See, e.g., 29 U.S.C. § 1191(a). It should be noted that this provision does not exist in the IRC, as the group health plan requirements of the IRC do not apply to health insurance issuers.

³⁰ P.L. 111-148, § 1563(e)-(f).

³¹ It should be noted that, perhaps because of a technical error, there is more than one Section 1563 contained in ACA. The Section 1563 relevant to this discussion is entitled "Conforming Amendments."

Enforcement of Relevant ACA Provisions in ERISA, the PHSA, and the IRC

As noted above, Part 7 of ERISA, Title XXVII of the PHSA, and Chapter 100 of the IRC generally apply federal health insurance standards to different types of private-sector health coverage. Further, the Secretaries of HHS, Labor, and the Treasury have shared interpretive and enforcement authority under these sections of the three statutes.³² In general, and discussed in more detail below, Part 7 of ERISA is administered by the Department of Labor and regulates health coverage provided by employers in the private sector. ERISA applies to insured and self-insured group health plans, as well as insurance issuers providing group health coverage. However, ERISA does not generally apply to governmental³³ or church plans. Title XXVII of the Public Health Service Act, administered by the Department of Health and Human Services, applies to self-insured governmental plans, health insurance issuers providing group health coverage, and coverage in the individual market. The IRC, as administered by the Department of Treasury, covers employment-based group health plans, including church plans, but does not apply to health insurance issuers. The enforcement mechanisms are different under each of the three statutes.³⁴

ERISA

The provisions of ACA were incorporated by reference into Part VII of ERISA. The Secretary of Labor may take enforcement action against group health plans of employers that violate ERISA, but may not enforce ERISA's requirements against health insurance issuers.³⁵

In addition, Section 502(a) of ERISA authorizes various civil actions that may be brought by a participant or beneficiary of a plan against group health plans and health insurance issuers. This section also provides for and limits the remedies (i.e., relief) available to a successful plaintiff. The Supreme Court has found that Section 502(a) contains "exclusive" federal remedies, and it preempts state or common law causes of action that may provide for more generous remedies than those available under ERISA. The preemption of these state law claims has been

³² See P.L. 104-191, §104; see also Notice of Signing of a Memorandum of Understanding among the Department of the Treasury, the Department of Labor, and the Department of Health and Human Services, 64 Fed. Reg. 70164, December 15, 1999.

³³ A "governmental plan," generally means a plan established or maintained for its employees by federal, state, or local governments. See 29 U.S.C. § 1002(32) and 42 U.S.C. § 300gg-91(d)(8).

³⁴ It should be noted that certain types of private insurance coverage that provide limited or supplementary health insurance benefits are not subject to the health insurance requirements of the IRC, the PHSA and ERISA. For example, these statutes carve out four categories of excepted benefits. See, e.g. 29 U.S.C. § 1191b(c). First are benefits that are not subject to these federal health insurance standards, including coverage for accident or disability income insurance, or automobile medical payment insurance, coverage for on-site medical clinics, and other insurance coverage under which the benefits for medical care are secondary or incidental to other insurance benefits. Second, certain benefits are excepted if they are offered "separately" and are not an integral part of the plan (e.g., a separate premium or contribution may be required). These benefits include "limited scope" dental or vision benefits and long-term care or nursing home benefits. Third, certain benefits that are offered "independently," such as coverage only for a specified disease or indemnity insurance. Fourth, certain plans that provide supplemental coverage to other plans (e.g., Medicare and Tricare) are considered excepted benefits. Presumably, plans such as these would not be subject to the new ACA provisions.

³⁵ 29 U.S.C. § 1132(b)(3).

controversial, as it can significantly affect a plaintiff's opportunity to recover damages under state law.³⁶ Since ACA did not amend Section 502 of ERISA, presumably the section would authorize review of claims arising out of a violation of the incorporated ACA provisions.

Among the claims that may be brought under Section 502(a) of ERISA, Section 502(a)(1)(B) authorizes a plaintiff (i.e., a participant or a beneficiary in an ERISA plan) to bring an action against the plan to recover benefits under the terms of the plan, or to enforce or clarify the plaintiff's rights under the terms of the plan.³⁷ Under this section, if a plaintiff's claim for benefits is improperly denied, the plaintiff may sue to recover the unpaid benefit. A plaintiff may also seek a declaration to preserve a right to future benefits or an injunction to prevent a future denial of benefits.³⁸ In terms of monetary remedies, Section 502(a)(1)(B) provides that a successful plaintiff may only receive the benefits the plaintiff would have been entitled to under the terms of the plan. Compensatory or punitive damages are not available under this subsection.³⁹

Section 502(a)(3) of ERISA permits a participant, beneficiary, or fiduciary to bring a civil action to enjoin any act or practice which violates ERISA or the terms of the plan, or to obtain "other appropriate equitable relief"⁴⁰ due to an ERISA violation. Section 502(a)(3) of ERISA has been referred to as a "catchall" provision—claims that may not be brought under other sections of 502, but are nevertheless violations of ERISA or the plan, can be brought under this section.⁴¹ However, lower courts have struggled with the scope and meaning of the term "other appropriate equitable relief" in Section 502(a)(3). This issue has been considered one of the most controversial areas of ERISA jurisprudence.⁴² The controversy has often arisen when plaintiffs have sought monetary recovery for ERISA Section 502(a)(3) violations. In general, the Supreme Court has interpreted the phrase "other appropriate equitable relief" in Section 502(a)(3) to be limited to traditional equitable relief, such as injunctions, restitution, and specific performance.⁴³

³⁶ The question of which state law claims are preempted by ERISA 502(a)(1) has received significant attention from the courts. For a discussion of this issue, see CRS Report RL34443, *Summary of the Employee Retirement Income Security Act (ERISA)*, by Patrick Purcell and Jennifer Staman.

³⁷ 29 U.S.C. § 1132(a)(1)(B).

³⁸ Jayne E. Zanglein, Susan J. Stabile, 31 *Journal of Pension Planning and Compliance* 1 (2005).

³⁹ In civil cases, courts sometimes award punitive (or exemplary) damages in addition to compensatory damages. Compensatory damages are meant to redress the "loss the plaintiff has suffered by reason of the defendant's wrongful conduct," in an attempt to "compensate" the injured person for the loss suffered. *State Farm Mut. Automobile Ins. Co. v. Campbell*, 538 U.S. 408, 416 (2003) (citing Restatement (Second) of Torts § 903, p.453-54 (1979)). Punitive damages, on the other hand, generally exceed the actual value of the harm caused by the defendant.

⁴⁰ Courts sometimes determine whether the relief a plaintiff seeks is legal or equitable. Colleen Murphy, *Money as a "Specific" Remedy*, 58 Ala. L. Rev. 119, 134 (2006). This distinction dates back to the "days of the divided bench," when England (and subsequently the United States) maintained separate courts of law and courts of equity. See generally *Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204, 212 (2002). One important way these courts differed from each other was the remedies available to plaintiffs. Historically, the most common remedy in the courts of law was money. *Id.* at 135. The most common remedy in the courts of equity was an order for an individual to do something or refrain from doing something, such as with an injunction. *Id.* The scope of remedies available at law and at equity have been the subject of debate. While there is no longer this divided court system, courts may still evaluate a claim based on this dichotomy.

⁴¹ See *Varity Corp. v. Howe*, 516 U.S. 489 (1996).

⁴² Roy F. Harmon III, "Equitable Relief" Claims under ERISA Section 502(a)(3), 20 *Benefits Law Journal* 33 (2007).

⁴³ See *Mertens v. Hewitt Associates*, 508 U.S. 248, 255 (1993). However, in *CIGNA Corp. v. Amara*, 131 S. Ct. 1866 (2011), the most recent case to address Section 502(a)(3) of ERISA, the Supreme Court discussed the idea that under certain circumstances, monetary compensation was available from courts of equity. While *CIGNA* was a case about a pension, not a health plan, some have questioned the ramifications of this case outside the pension plan context. See e.g., James P. McElligott Jr., *Amara Adds to Health Plan Administration Challenges*, *BNA Pension & Benefits Daily*, (continued...)

The PHSA

In general, the private health insurance requirements of Title XXVII of the Public Health Service Act apply to health insurance issuers and to self-funded non-federal governmental group plans.⁴⁴ Prior to ACA, state and local governments could elect to exempt their plans from certain requirements of the PHSA, subject to certain exceptions.⁴⁵ However, this election is not applicable to the provisions added to the PHSA by ACA, and thus these plans are subject to ACA's federal health insurance standards.⁴⁶

Enforcement of the PHSA requirements is different for health insurance issuers than for governmental plans. The Secretary of Health and Human Services is the primary enforcer of the PHSA requirements with respect to governmental plans. But with respect to health insurance issuers, states are the primary enforcers of the private health insurance requirements.⁴⁷ If the Secretary determines that a state has failed to substantially enforce a provision of Title XXVII of the PHSA with respect to health insurance issuers in the state, the Secretary must enforce these provisions.⁴⁸ While the statute does not specify what a state needs to do in order to be considered "substantially enforcing" the requirements of the PHSA, regulations outline the procedure to be followed by HHS in making a determination as to whether federal enforcement is needed.⁴⁹ It may be noted that Secretary Sebelius sent a letter to the governors of each state requesting information on whether each state had the authority to enforce federal health insurance standards in ACA. The National Association of Insurance Commissioners (NAIC) responded to the Secretary, opining that, by and large, states do have statutes in place that would allow them to enforce the ACA provisions.⁵⁰

The Secretary may impose a civil monetary penalty on insurance issuers that fail to comply with the PHSA requirements. The maximum penalty imposed under the PHSA is \$100 per day for each individual with respect to which such a failure occurs.⁵¹ Similar to the IRC, certain minimum penalty amounts may apply to a plan or employer if the violation is not corrected within a specified period, or if a violation is considered to be more than de minimis. In determining the amount of the penalty, the Secretary must take into account the entity's previous record of compliance with the PHSA provisions. In addition, a penalty may not be imposed for a violation if it is established to the Secretary's satisfaction that none of the entities knew (or if exercising

(...continued)

Sept. 21, 2011.

⁴⁴ 42 U.S.C. § 300gg-21(a)(1).

⁴⁵ 42 U.S.C. § 300gg-21(a)(2)(A).

⁴⁶ However, HHS has indicated that self-funded state and local governmental plans may still make an election to opt out of some of the requirements of Title XXVII of the PHSA created prior to ACA (e.g., the mental health parity requirements). See HHS memorandum from Steve Larson dated 9/21/10, *Amendments to the HIPAA opt-out provision (formerly section 2721(b)(2) of the Public Health Service Act) made by the Affordable Care Act*, available at http://www.hhs.gov/ocio/regulations/opt_out_memo.pdf.

⁴⁷ 42 U.S.C. § 300gg-22(a)(1).

⁴⁸ 42 U.S.C. § 300gg-22(a)(2).

⁴⁹ See 45 C.F.R. § 150.207 et seq.

⁵⁰ Letter from Jane Cline, President of the NAIC to Secretary Kathleen Sebelius (Aug. 5, 2010), available at http://naic.org/documents/index_health_reform_section_letter_kathleen_sebelius.pdf. See also NAIC's Survey on State Authority to Enforce ACA Immediate Implementation Provisions, available at http://www.naic.org/documents/index_health_reform_section_ACA_state_enforcement_authority.pdf.

⁵¹ 42 U.S.C. § 300gg-22(b)(2)(C)(i).

reasonable diligence would have known) that the violation existed. If the violation was due to reasonable cause and not willful neglect, a penalty would not be imposed if the violation were corrected within 30 days of discovery. Entities found to violate the PHSA requirements may challenge the penalty in a hearing subject to a decision by an administrative law judge. Following this administrative hearing, entities may file an action for judicial review.

The IRC

In general, the group health provisions in Chapter 100 of the Internal Revenue Code apply to all group health plans (including church plans), but they do not apply to governmental plans and health insurance issuers. Under the IRC, the group health plan requirements are enforced through the imposition of an excise tax.⁵² For single-employer plans, employers are generally responsible for paying this excise tax. Under multiemployer plans, the tax is imposed on the plan.⁵³

A group health plan that fails to comply with the pertinent requirements in the IRC may be subject to a tax of \$100 for each day in the noncompliance period⁵⁴ with respect to each individual to whom such failure relates. However, if failures are not corrected before a notice of examination for tax liability is sent to the employer, and these failures occur or continue during the period under examination, the penalty will not be less than \$2,500. Where violations are considered to be more than de minimis, the amount will not be less than \$15,000.⁵⁵ Limitations on a tax may be applicable under certain circumstances (e.g., if the person otherwise liable for such tax did not know or if exercising reasonable diligence would not have known that such violation existed). Since the provisions of ACA are incorporated by reference into Chapter 100 of the IRC, and Section 4980D of the IRC imposes a tax on any failure of a group health plan to meet the requirements of the chapter, group health plans subject to the Internal Revenue Code could be subject to the excise tax for violations of the ACA provisions.

The following table summarizes applicability and enforcement mechanisms of the PHSA, ERISA, and the IRC.

⁵² 26 U.S.C. § 4980D.

⁵³ 26 U.S.C. § 4980D(e).

⁵⁴ The noncompliance period begins on the date when the failure first occurs, and ends on the date the failure is corrected. 26 U.S.C. § 4980D(b)(2).

⁵⁵ Church plans are exempt from the minimum penalty amounts. *See* 26 U.S.C. § 4980D(b)(3)(C).

Table 1. Private Health Insurance Requirements in the IRC, the PHSA, and ERISA
 Applicability and Enforcement

Statute	Application	Enforcement Tools
ERISA, Part 7	Group health plans (including self-insured plans) of private sector employers and health insurance issuers	Secretary of Labor/ employee right to sue
Public Health Service Act, Title XXVII	Health insurance issuers and self-insured governmental plans	States have primary enforcement responsibility against health insurance issuers; Secretary of HHS can impose civil monetary penalties
Internal Revenue Code, Chapter 100	Group health plans, including church plans	Excise tax

Enforcement of Relevant ACA Provisions in Health Coverage Provided Under a Health Insurance Exchange

ACA specifies that by January 1, 2014, each state must establish an American Health Benefit Exchange (“exchange”) that is either a state governmental agency or a nonprofit entity, in order to provide health coverage to qualified individuals and/or employers.⁵⁶ In general, if a state does not elect to establish an exchange, or if the Secretary determines that a state will not have an operational exchange by January 1, 2014, or has not taken certain specified actions, the Secretary must establish and operate an exchange within the state.⁵⁷ Each state exchange must, among other things, facilitate the purchase of “qualified” health plans. Qualified health plans are defined by ACA as health plans that are, among other things, offered by a “health insurance issuer” that “is licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage....”⁵⁸ An exchange is prohibited from making available any health plan that is not a qualified plan.⁵⁹ Individual health insurance coverage and group health plans for small employers will be able to be offered both inside and outside of an exchange.⁶⁰ Large group health plans can be offered outside an exchange, and beginning in 2017,

⁵⁶ P.L. 111-148, §§ 1311(b)(1), 1311(d)(1).

⁵⁷ P.L. 111-148, § 1321(c).

⁵⁸ P.L. 111-148, § 1301(a)(1)(C).

⁵⁹ P.L. 111-148, § 1311(d)(2).

⁶⁰ P.L. 111-148, § 1312(d). Before 2016, states will have the option to define “small employers” either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. P.L. 111-148, § 1304(b).

states may allow issuers of health insurance coverage in the large group market to offer qualified health plans through an exchange at the discretion of each state.⁶¹

Given that “qualified health plans” must be offered by health insurance issuers, it appears that these plans will be subject to the same federal health insurance standards included in ERISA and the PHSA.⁶² Thus, the same federal enforcement mechanisms discussed above may apply to qualified health plans participating in a health insurance exchange. However, qualified health plans participating in an exchange will be subject to numerous additional requirements that may be enforced by the exchange, by the Secretary of HHS, or by the state. Enforcement of these additional requirements for qualified health plans participating in a health insurance exchange will likely be the topic of further discussion as state exchanges are established.

Author Contact Information

Jennifer Staman
Legislative Attorney
jstaman@crs.loc.gov, 7-2610

⁶¹ P.L. 111-148, § 1312(f)(2). A “large employer” will be an employer that had an average of at least 101 employees the preceding calendar year and at least one employee on the first day of the plan year. P.L. 111-148, § 1304(b).

⁶² See CRS Report R41269, *PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange*, by Bernadette Fernandez.