



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

Jennifer Staman
Legislative Attorney

February 7, 2011

Congressional Research Service

7-5700

www.crs.gov

R41624

Summary

The Patient Protection and Affordable Care Act (PPACA), as amended to date, greatly expanded the scope of federal regulation over health insurance coverage provided through employment-based group health coverage, as well as coverage sold in the individual insurance market. Federal health insurance standards created by PPACA include an extension of dependent coverage to age 26; 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 standards began to take effect in 2010, others are scheduled to begin in 2014. These new health insurance 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). While PPACA does not expressly include any new means for enforcing these new health insurance standards, enforcement of these reforms may be carried out through mechanisms that existed prior to PPACA 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 enforcement provisions in ERISA, the PHSA, and the IRC that could be used to enforce new PPACA health insurance standards.

In addition, PPACA 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. PPACA'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.

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Introduction

According to census data, in 2009, approximately 63.9% 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 recently enacted Patient Protection and Affordable Care Act (PPACA), 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

PPACA 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 PPACA'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 Title I of PPACA 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

¹ See U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2009* at 22.

² P.L. 111-148 (2010), §§ 1001-104, 1201-1255. PPACA 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 "PPACA."

³ For a discussion of these new PPACA requirements, see CRS Report R40942, *Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)*, by Hinda Chaikind, Bernadette Fernandez, and Mark Newsom.

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 Besides the creation of new private health insurance standards, Title I of PPACA contains a number of additional requirements that affect individuals and employers. For example, PPACA 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 PPACA, certain large employers may be subject to a tax penalty if they do not offer coverage, (continued...)

However, since PPACA amends three preexisting statutes—the Employee Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC)—enforcement under federal law may be carried out through mechanisms in those statutes. This report examines these selected federal mechanisms.⁸

In addition, PPACA 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.⁹ PPACA'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 briefly address enforcement of health coverage offered through an exchange.¹⁰

Background on State and Federal Health Insurance Regulation

In order to examine how PPACA'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 to be financially solvent and to pay claims promptly, to regulate insurance ratings and/or premiums, 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*,¹¹ 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 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."¹² However, under the

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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 PPACA.

⁸ It should be noted that Section 1001 of PPACA 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.

⁹ P.L. 111-148, § 1301 et seq.

¹⁰ It should be noted that a number of bills have been introduced that would repeal or significantly amend PPACA. *See, e.g.,* H.R. 2, 112th Cong. (2011). In addition, several lawsuits have been filed that challenge provisions of PPACA 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 PPACA in its current form.

¹¹ 322 U.S. 533 (1944).

¹² 15 U.S.C. § 1012(a).

act, Congress also reserved to itself the right to enact federal statutes that specifically relate to “the business of insurance.”¹³ Pursuant to this right, Congress has passed legislation which regulates insurance in particular instances.

In the 1970s, the federal government began to take a more active role in health insurance regulation, in particular with respect to employment-based health coverage under ERISA.¹⁴ ERISA provides a comprehensive federal scheme for the regulation of private-sector employee benefit plans. Besides the regulation of pension plans, ERISA also regulates welfare benefit plans¹⁵ 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 affects the regulation of ERISA plans. Section 514(a) of ERISA preempts state laws that “relate to” an employee benefit plan.¹⁶ However, ERISA sets out exceptions to the preemption provision, including an exemption for state laws that regulate insurance.¹⁷ 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.¹⁸

In the 1980s and 1990s, Congress enacted legislation establishing minimum national standards for private health insurance.¹⁹ In 1996, Congress passed one of the most comprehensive federal acts affecting private health insurance, the Health Insurance Portability and Accountability Act (HIPAA).²⁰ In general, 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, with respect to group health coverage, group health plans and health insurance issuers that provided coverage were

¹³ 15 U.S.C. § 1012(b).

¹⁴ Mila Kofman and Karen Pollitz, *Health Insurance Regulation by States and the Federal Government: A Review of Current Approaches and Proposals for Change*, Georgetown University Health Policy Institute, available at <http://www.allhealth.org/briefingmaterials/HealthInsuranceReportKofmanandPollitz-95.pdf>.

¹⁵ 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).

¹⁶ 29 U.S.C. § 1144(a).

¹⁷ 29 U.S.C. § 1144(b).

¹⁸ It should be noted PPACA 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.

¹⁹ *See* Kofman and Pollitz, note 13 *supra*.

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.

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 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, as amended by HIPAA, apply to different types of private health insurance coverage and contain different types of enforcement mechanisms. Following enactment of HIPAA, Congress subsequently 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," which preserves 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.

PPACA significantly amended and expanded upon these federal health insurance standards, adding several new requirements that group health plans and health insurance issuers in the group and individual markets must follow. Title I of PPACA amended the PHSa, and these provisions are incorporated by reference into ERISA and the IRC.³⁰ Section 1563 of PPACA 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 PPACA, the provisions of PPACA apply.³¹ Because PPACA health insurance standards are incorporated by

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 PPACA, 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 (continued...)

reference into ERISA and the IRC, the enforcement mechanisms of these two laws may be applied.

Enforcement of Relevant PPACA Provisions in ERISA, the PHS Act, and the IRC

As noted above, Part 7 of ERISA, Title XXVII of the PHS Act, and Chapter 100 of the IRC generally apply federal health insurance standards to different types of private 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 group health plans that are both insured and self-insured, as well as health insurance issuers providing group health coverage. However, ERISA does not generally apply to governmental plans³³ 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

As mentioned above, ERISA provides a comprehensive federal scheme for the regulation of private-sector employee benefit plans. HIPAA created Part 7 of ERISA, which is applicable to group health plans, including self-insured plans offered by private-sector employers, and health insurance issuers providing group health coverage. The provisions of PPACA were incorporated by reference into this part. The Secretary of Labor may impose civil money penalties on the

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PPACA. The Section 1563 relevant to this discussion is entitled “Conforming Amendments.”

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 PHS Act 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 PPACA provisions.

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 both group health plans and health insurance issuers. This section also provides for remedies (i.e., relief) available to a successful plaintiff. It should be noted that the Supreme Court has found the enforcement scheme under Section 502(a) to contain "exclusive" federal remedies, and the section has been held to preempt state or common law causes of action that may provide for more generous remedies than what is available under ERISA. The preemption of these state law claims has been controversial, as it can significantly affect a plaintiff's opportunity to recover damages under state law.³⁶ PPACA did not amend Section 502 of ERISA, and presumably the section would authorize review of claims arising out of a violation of the incorporated PPACA 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

³⁵ 29 U.S.C. § 1132(b)(3).

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).

However, 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 relief 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 provide only for traditional equitable relief, such as injunctions, restitution, and specific performance.⁴³

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 PPACA, under HIPAA and subsequent acts, state and local governments could elect to exempt their plans from the requirements of the PHSa, subject to certain exceptions.⁴⁵ However, this election is not applicable to the provisions added to the PHSa by PPACA, and thus these plans are subject to PPACA’s federal health insurance standards.⁴⁶

Enforcement of the PHSa requirements is different for health insurance issuers than for governmental plans. The Secretary is the primary enforcer of the PHSa requirements with respect to governmental plans. But with respect to health insurance issuers, the PHSa allows states to be the primary enforcers of the private health insurance requirements.⁴⁷ If the Secretary of HHS 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 PPACA. 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 PPACA provisions.⁵⁰

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).

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 PPACA (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 PPACA Immediate Implementation Provisions, available at http://www.naic.org/documents/index_health_reform_section_ppaca_state_enforcement_authority.pdf.

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 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 Department of Treasury can enforce the group health plan requirements 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 PPACA 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 PPACA provisions.

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

⁵¹ 42 U.S.C. § 300gg-22(b)(2)(C)(i).

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 PHS Act, 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	Civil monetary penalties against group health plans; 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

Source: Congressional Research Service

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

PPACA 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 PPACA 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 health insurance issuers, it appears that these plans will be subject to the same federal health insurance standards included in ERISA, the PHSA, and the IRC.⁶² Thus, it seems that the same federal enforcement mechanisms discussed above could 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 another entity. Enforcement of these additional requirements for qualified health plans participating in a health insurance exchange will likely be the topic of further exploration and analysis if and when the 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.