Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement

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SUMMARY

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Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement

According to the U.S. Census Bureau, in 2018, over 65% of the U.S. population was covered by private-sector health insurance offered either through an employer or a union, or directly purchased by an individual from an insurance company. Private health insurance regulation covers a wide array of issues, including the benefits that must be offered, the financial responsibilities of insurers and insureds, and mechanisms for protecting consumer rights. As Congress engages in perennial debate over amendments to federal private health insurance regulation, it faces the question of how such requirements may be enforced. This report provides a brief overview of the basic legal structure governing federal regulation of the nature and content of private health insurance, and examines existing provisions that may be used to enforce these health insurance standards (commonly referred to as private health insurance "market reforms").

While states were traditionally the principal regulators of health insurance, since the 1970s the federal government has become increasingly more involved. For example, in 1974, Congress passed the Employee Retirement Income Security Act (ERISA) to regulate private-sector employee benefit plans. Under the Act, plans that provide medical, surgical, and other health benefits are subject to, among other things, fiduciary standards, reporting and disclosure requirements, and procedures for appealing a denied claim for benefits. In 1996, Congress passed the Health Insurance Portability and Accountability Act (HIPAA), which included health insurance provisions designed to reduce the possibility that individuals and certain employees would lose existing health plan coverage, and to help individuals maintain coverage when changing jobs or purchasing coverage on their own. These and other federal provisions laid the groundwork for more comprehensive health reform legislation in 2010, the Patient Protection and Affordable Care Act (ACA), which greatly expanded the scope of federal regulation over private health insurance coverage. Among many other things, ACA established several market reforms largely designed to expand access to private health insurance. These reforms include a required extension of dependent coverage, if such coverage is offered, to age twenty-six; a bar on lifetime and certain annual benefit limits; coverage of certain essential health benefits; a prohibition on health insurance rescissions except under limited circumstances; and coverage of certain preventive health services without cost sharing. Following enactment of ACA, Congress created some additional private health insurance requirements, including mandated coverage for Coronavirus Disease 2019 (COVID-19) testing and related items and services.

Currently, the federal private insurance market reforms included in ACA and other federal laws are largely codified or incorporated by reference as similar provisions in three separate federal statutes: Title XXVII of the Public Health Service Act (PHSA); Part 7 of Title I of ERISA; and Chapter 100 of the Internal Revenue Code (IRC). Each statute applies to different types of private health coverage and contains different types of enforcement mechanisms. The requirements of Title XXVII of the PHSA generally apply to *health insurers* offering coverage in the group (i.e., employment-based) and individual markets, as well as *health plans for state and local government employees.* With respect to health insurers, the PHSA allows states to be the primary enforcers of the federal private health insurance requirements, but the Secretary of Health and Human Services (HHS) assumes this responsibility if it is determined that a state has failed to "substantially enforce" the federal PHSA provisions. The HHS Secretary may impose a civil monetary penalty on health insurers that fail to comply with the PHSA requirements. In general, Part 7 of Title I of ERISA applies to health coverage offered through *private-sector employee benefit plans*, both insured (i.e., purchased from an insurance carrier) or self-insured (funded directly by the employer). In cases where benefits are not provided in accordance with the requirements of the Act, ERISA authorizes plan participants to bring a civil action against the plan or other responsible persons to address alleged infractions. The Labor Department is charged with administration of this part of ERISA, and the Agency has authority to investigate violations, bring civil suits, and assess civil penalties to address violations in specified circumstances. Similar to ERISA, Chapter 100 of the IRC also applies to employment-based group health coverage, and the Department of the Treasury can enforce the health plan requirements through the imposition of an excise tax. The tax is $100 per day per each affected individual during a noncompliance period, which can be reduced under certain conditions. Employers and other persons liable for the excise tax must self-report this obligation to the IRS or potentially face additional tax penalties and interest.

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According to the U.S. Census Bureau, in 2018, over 65% of the U.S. population was covered by private health insurance offered either through an employer or a union, or purchased directly by an individual from an insurance company.[1] Private health insurance regulation covers a wide array of issues, including the benefits that must be offered, the financial responsibilities of insurers and insureds, and mechanisms for protecting consumer rights. These requirements are commonly referred to as private health insurance "market reforms."[2] The federal reforms that are the subject of this report[3] may apply to two categories of coverage: "group health plans" and "health insurance issuers."[4] Group health plans broadly refer to employment-based health insurance plans that provide medical care to employees, former employees, and their dependents.[5] Group health plans can be insured (i.e., coverage purchased from an insurance carrier) or self-insured (funded directly by the employer).[6] In general, health insurance issuers are insurance companies that issue a policy or contract to provide employment-based, group health insurance coverage, *or* coverage sold on the individual insurance market.[7]

As Congress engages in perennial debate over amendments to health insurance market reforms, it faces the question of enforcement of the federal standards.[8] This report provides a brief overview of the evolution of federal private health insurance market reforms and examines key provisions that authorize federal agencies, states, and private entities to enforce these reforms in the event of noncompliance.

[1] U.S. CENSUS BUREAU, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018 3 (2019), https://www.census.gov/library/publications/2019/demo/p60-267.html.

[2] For a broad discussion of these reforms, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, coordinated by Bernadette Fernandez.

[3] This report does not address other federal laws that may pertain to the provision of health insurance coverage, such as the Age Discrimination in Employment Act (ADEA) and the Americans with Disabilities Act (ADA). *See generally* 29 U.S.C. §§ 621–34 (ADEA); 42 U.S.C. §§ 12101–12213 (ADA). Additionally, a discussion of the tax treatment of private health insurance coverage under the Internal Revenue Code is beyond the scope of this report. Notably, the Patient Protection and Affordable Care Act (ACA) established other requirements related to the insurance market. For example, pursuant to ACA, American Health Benefit Exchanges are established in each state to provide health insurance for qualified individuals and small employers. These insurance marketplaces must, among other things, facilitate the purchase of "qualified health plans" offered by health insurance issuers. For more information on exchanges, see CRS Report R44065, *Overview of Health Insurance Exchanges*, by Vanessa C. Forsberg.

[4] Some private health insurance market reforms apply to certain types of insurance coverage, but not others. *See, e.g.*, 42 U.S.C. § 300gg-2 (guaranteed renewability requirements apply only to health insurance issuers, not group health plans). For a list of the applicability of federal requirements to different types of coverage, see Table 1 of CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*, coordinated by Bernadette Fernandez, *supra* note 2.

[5] *See, e.g.*, 42 U.S.C. § 300gg-91(a)(1).

[6] *See id.*

[7] Specifically, a "health insurance issuer" "means an insurance company, insurance service, or insurance organization . . . which is licensed to engage in the business of insurance in a state and which is subject to state law that regulates insurance." *See id.* § 1191b(b)(2). This report will hereinafter refer to "health insurance issuers" as "insurers."

[8] There are federal requirements that provide for, among other things, appeals of denied claims for benefits. *See, e.g.*, 42 U.S.C. § 300gg-19. While these required processes may be seen as a way to enforce benefit rights, this report will address other judicial and administrative enforcement tools available under federal law.

Background on Private Health Insurance Market Reforms

To examine how federal private health insurance market reforms are enforced, it is helpful to first understand the basic legal landscape of this regulatory arena. Historically, health insurance matters were mainly regulated at the state, rather than the federal, level.[9] The states' role in the regulation of health insurance was viewed, at least in part, as a remnant of the traditional notion that insurance was not commerce, and therefore could not be regulated by the federal government pursuant to the U.S. Constitution's Commerce Clause.[10] However, in 1944, the Supreme Court in *United States v. South-Eastern Underwriters Ass'n* generally affirmed the federal government's right to regulate the practices of insurers under the Commerce Clause.[11] In response to this decision, and concerns over the continued validity of state insurance regulation and taxation of insurance premiums,[12] Congress passed the McCarran-Ferguson Act, which expressly recognized the role of the states in the regulation of insurance.[13] However, under the Act, Congress also reserved the right to enact federal statutes that specifically relate to "the business of insurance."[14] Consistent with this right, Congress has passed legislation that regulates insurance in particular instances. While in recent decades the federal government has assumed a larger role in regulating private health insurance coverage, states continue to maintain comprehensive standards for health insurance and insurers.[15]

ERISA

The first significant federal venture into the realm of private health insurance regulation came in the 1970s, when Congress passed the Employee Retirement Income Security Act (ERISA) to

[9] *See, e.g.*, Elizabeth Weeks Leonard, *Rhetorical Federalism: The Value of State-Based Dissent to Federal Health Reform*, 39 HOFSTRA L. REV. 111, 152 (2010) ("Insurance regulation was long considered within core state police powers to protect the health, safety, and welfare of their citizens.").

[10] *See generally* Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J.L. & MED. 395, 397–98 (2005). In *Paul v. Virginia*, the Supreme Court ruled that "[i]ssuing a policy of insurance is not a transaction of [interstate] commerce." 75 U.S. (8 Wall.) 168 (1868). However, years later, in *United States v. South-Eastern Underwriters Ass'n*, the Court held that the federal antitrust laws are applicable to an insurance association's interstate activities in restraint of trade. 322 U.S. 533, 553–53 (1944).

[11] 322 U.S. 533 (1944).

[12] *See, e.g.*, GARY M. COHEN, 2 NEW APPLEMAN ON INSURANCE LAW § 8.01 (Law Library ed. 2020) ("Notwithstanding the Court's effort in *South-Eastern Underwriters* to provide assurance that state statutes regulating insurance would remain enforceable in the absence of federal action, Congress acted quickly to leave no doubt about the issue. At the urging of the insurance industry, which at that time was anxious to preserve the system of state regulation, in 1945 Congress passed the McCarran-Ferguson Act.").

[13] 15 U.S.C. §§ 1011–1015. Section 2(a) of the Act provides: "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." *Id.* § 1012(a).

[14] *Id.* § 1012(b).

[15] While state insurance laws vary, each state has requirements related to the finances, management, and business practices of insurers, as well as an array of standards relating to, among other things, mandated health benefits and consumer protection (e.g., rate review of health insurance premiums). *See, e.g.*, Joshua Phares Ackerman, *The Unintended Federalism Consequences of the Affordable Care Act's Insurance Market Reforms*, 34 PACE L. REV. 273, 281–84 (2014) ("State insurance regulations exhibit considerable breadth and complexity. Generally speaking, however, the regulations fit into three broad categories—solvency, rate regulation, and market conduct.").

regulate private-sector employee benefit plans.[16] While ERISA was primarily enacted to reform federal pension plan regulation, certain provisions of the Act apply to "welfare benefit plans,"[17] including those that provide medical, surgical, and other health benefits.[18] Under the Act's original provisions, employment-based plans that provide health benefits, like other employee benefit plans governed by ERISA, must comply with various basic standards, including plan fiduciary standards,[19] and reporting and disclosure requirements.[20]

Although not a requirement governing the specific terms of employment-based health insurance coverage, a critical feature of ERISA's regulatory regime is its preemption of state law. Section 514(a) of ERISA preempts state laws that "relate to" any employee benefit plan.[21] Under this provision, ERISA may supersede state laws that, for example, aim to regulate plan benefits, or the administration, operation, or structure of employee benefit plans.[22] Based on judicial precedent interpreting Section 514 of ERISA, states cannot, for example, require employers to provide a minimum level of coverage or specific health benefits as part of their benefit plans.[23] Importantly, ERISA also sets out certain exceptions to this preemption provision, including an exemption for state laws that "regulate insurance."[24] This so-called "savings clause" permits states to regulate health insurance offered through ERISA-governed plans without running afoul of ERISA's preemptive scheme, but not the plans themselves.[25]

[16] Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (1974).

[17] ERISA considers a number of nonpension 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).

[18] *See* Phyllis C. Borzi, *There's "Private" and Then There's "Private": ERISA, Its Impact, and Options for Reform*, 36 J.L. MED. & ETHICS 660, 660–62 (2008), for a discussion of the reasoning behind the disparity between regulation of pension and welfare benefit plans under ERISA. *See also generally* Erin C. Fuse Brown & Elizabeth Y. McCuskey, *Federalism, ERISA, and State Single-Payer Health Care*, 168 U. PA. L. REV. 389, 394 (2020) (describing ERISA as "an interloper in federal health insurance regulation—an employee-benefits statute not originally intended to govern health care, but which now exerts a powerful influence over it").

[19] 29 U.S.C. §§ 1101–1114.

[20] *Id.* §§ 1021–1031.

[21] *Id.* § 1144(a).

[22] *See, e.g.*, Gobeille v. Liberty Mut. Ins. Co., 136 S. Ct. 936 (2015) (holding that ERISA preempted a Vermont law and regulation that governed health insurance plan reporting and disclosure requirements because they interfered with "fundamental components" of ERISA's regulation of plan administration).

[23] *See, e.g.*, Shaw v. Delta Air Lines, Inc., 463 U.S. 85 (1982); Standard Oil v. Agsalud, 633 F.2d 760 (9th Cir. 1980), *aff'd mem.*, 454 U.S. 801 (1981).

[24] 29 U.S.C. § 1144(b).

[25] *Id.* § 1144(b)(2)(B). However, under what is commonly referred to as ERISA's "deemer clause," a state law that "purport[s] to regulate insurance" cannot deem an employee benefit plan to be an insurance company for purposes of regulation. *See Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 733 (1985) (discussing ERISA's "saving clause" and "deemer clause"). In interpreting this provision, the Supreme Court has held that a self-insured health plan cannot be "deemed" an insured plan for the purpose of state regulation. FMC Corp. v. Holliday, 498 U.S. 52 (1990).

While states may generally be able to regulate health insurance, the savings clause does not permit states to impose regulation on a common type of workplace health coverage—self-insured plans. Under self-funded (or self-insured) plans, instead of using health insurance (i.e., where an employer pays a premium to an insurer to cover the claims of plan participants), an employer acts as the insurer itself and pays the health care claims of the plan participants. Accordingly, an employee benefit plan that provides health benefits through an insurance company can, in effect, be regulated by state insurance law as well as ERISA. On the other hand, a plan that is self-insured is only subject to ERISA's requirements and is immune from state law. *See id*. at 61 (concluding that an ERISA-regulated, self-insured health plan could not be an insured plan for purposes of state regulation).

Health Insurance Portability and Accountability Act (HIPAA)

Following the enactment of ERISA, Congress took steps to regulate the nature and content of private-sector health insurance. For example, in 1996, Congress passed HIPAA in part "to improve portability and continuity of health insurance coverage in the group and individual markets."[26] HIPAA's health insurance provisions were primarily designed to prevent individuals from losing existing health insurance plan coverage by assisting individuals in maintaining coverage when changing jobs or purchasing coverage on their own.[27] In the context of employment-based health coverage, the Act generally restricted, under certain circumstances, the period of time that an individual could be excluded from job-based health coverage because of a preexisting condition.[28] The Act also prohibited plans and insurers 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.[29]

HIPAA established the basic statutory structure for current federal private health insurance market reforms. HIPAA's health insurance requirements were largely set out as somewhat similar provisions in three federal statutes: Part 7 of Title I of ERISA; Title XXVII of the Public Health Service Act (PHSA); and Chapter 100 of the Internal Revenue Code (IRC).[30] The PHSA, ERISA, and the IRC generally apply parallel federal health insurance standards to different types of private health insurance coverage.[31] Following enactment of HIPAA, Congress passed additional federal laws governing other aspects of private health insurance coverage, and the provisions generally followed this triplicate regulatory model. These include the Newborns' and Mothers' Health Protection Act,[32] which establishes minimum hospital stay requirements following the birth of a child; the Mental Health Parity Act of 1996, as amended by the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008,[33] providing for parity (i.e., comparable health benefit requirements and limitations) between medical/surgical benefits and

[26] Pub. L. No. 104-191, 110 Stat. 1936, 1936 (1996).

[27] *See generally* Colleen Medill, *HIPAA and its Related Legislation: A New Role For ERISA in the Regulation of Private Health Care Plans?*, 65 TENN. L. REV. 485, 496–97 (1998).

[28] *See, e.g.*, 29 U.S.C. § 1181.

[29] *See, e.g.*, *id*. § 1182. 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 twelve 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. *See* 42 U.S.C. §§ 300gg-41–300gg-44.

[30] 29 U.S.C. §§ 1181–1191c; 42 U.S.C. §§ 300gg–300gg-95; 26 U.S.C. §§ 9801–9834.

[31] As discussed later in the report, Title I, Part 7 of ERISA is generally administered by the U.S. Department of Labor and regulates health insurance coverage provided by private employers. 29 U.S.C. § 1003(a). ERISA applies to group health plans and group plan insurers, but generally does not apply to governmental plans, church plans, or health insurance coverage sold to individuals. *Id*. § 1003(b). Title XXVII of the PHSA, administered by the U.S. Department of Health and Human Services, applies to health insurance issuers providing individual and group health insurance coverage, and self-insured governmental plans. *See* 42 U.S.C. § 300gg-21(a). The IRC, as administered by the U.S. Department of the Treasury, covers employment-based group health plans, including church plans, but does not apply to governmental plans or health insurance coverage offered in the individual market. *See* 26 U.S.C. § 9831.

[32] Pub. L. No. 104-204, §§ 603–705, 110 Stat. 2874, 2935–2937 (1996).

[33] Pub. L. No. 104-204, §§ 701–603, 110 Stat. 2874, 2944–2950 (1996); Pub. L. No. 110-343, §§ 511–512, 122 Stat. 3765, 3881–3893 (2008).

mental health/substance use disorder benefits; the Genetic Information Nondiscrimination Act,[34] which prohibits discrimination by plans and health insurers based on genetic information; and Michelle's Law,[35] 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.

The Patient Protection and Affordable Care Act (ACA) and Beyond

In 2010, Congress enacted comprehensive health reform legislation—the Patient Protection and Affordable Care Act (ACA)[36]—to increase the number of individuals covered by health insurance and decrease health care costs.[37] Among other things, ACA revamped many HIPAA insurance provisions and greatly expanded the scope of federal regulation over private health insurance coverage by establishing numerous market reforms largely designed to expand access to private health insurance. These reforms include a required extension of dependent coverage, if such coverage is offered, to age twenty-six;[38] a bar on lifetime and certain annual benefit limits;[39] coverage of certain essential health benefits;[40] a prohibition on health insurance rescissions (except under limited circumstances);[41] and coverage of preventive health services without cost sharing.[42] In addition, ACA prohibits plans and insurers in both the individual and group markets from excluding coverage based on an individual's preexisting health conditions, and generally requires all group health plans and insurers to offer coverage on a guaranteed issue basis (i.e., accept every applicant for coverage).[43] While ACA created many new federal health insurance standards, the Act generally retains the basic statutory structure for these requirements, as the reforms were added to PHSA and incorporated by reference into ERISA and the IRC.[44]

Following ACA's enactment, Congress imposed additional requirements on group health plans and insurers that offer private health insurance. In 2018, for example, Congress passed the Patient Right to Know Drug Prices Act, which prohibits certain so-called pharmacy "gag clauses."[45] These clauses prevent pharmacies from informing patients that they could pay less for a prescription drug if they pay entirely out-of-pocket, rather than using insurance to acquire the

[34] Pub. L. No. 110–233, §§ 101–103, 122 Stat. 881, 883–899 (2008).

[35] Pub. L. No. 110-381, § 2, 122 Stat. 4081, 4081–4086 (2008).

[36] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). ACA was amended by the Health Care Education and Reconciliation Act (HCERA) of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010). These acts are collectively referred to in this report as the "ACA."

[37] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 538 (2012).

[38] 42 U.S.C. § 300gg-14.

[39] *Id.* § 300gg-11.

[40] *Id.* § 300gg-6.

[41] *Id.* § 300gg-12.

[42] *Id.* § 300gg.

[43] *Id.* §§ 300gg-1, 300gg-2.

[44] Although beyond the scope of this report, the Supreme Court has agreed to review a legal challenge to the constitutionality of ACA's requirement for individuals to maintain health insurance (the so-called "individual mandate"), and the continued validity of the remainder of the Act should the individual mandate be struck down, including the Act's health insurance market reforms. Texas v. California, 140 S. Ct. 1262 (No. 19-840, 19-1019) (consolidated cases). Oral arguments in *California v. Texas* were held on November 10, 2020, with a decision expected sometime in 2021. For more on the *Texas v. California* case, see CRS Legal Sidebar LSB10547, *California v. Texas: The Fate of the Affordable Care Act*, by Edward C. Liu.

[45] Pub. L. No. 115-263, 132 Stat. 3672, 3672 (2018) (codified at 42 U.S.C. § 300gg-19b).

drug.[46] Additionally, as part of federal legislation to combat the Coronavirus Disease 2019 (COVID-19) global pandemic, group health plans and health insurers must cover certain COVID-19 testing, the administration of such tests, and related items and services, as well as "qualifying coronavirus preventive services," which may include vaccines when available.[47] These items and services must be provided to participants without cost sharing.[48]

Enforcement of Federal Private Health Insurance Market Reforms in ERISA, the PHSA, and the IRC

As discussed above, the private health insurance market reforms were primarily added to, or incorporated by reference in, three separate laws: Title XXVII of the PHSA; Title I, Part 7 of Title I of ERISA; and Chapter 100 of the IRC. The three laws generally apply similar federal health insurance standards to different types of private-sector health coverage:

- Title XXVII of the PHSA, administered by the U.S. Department of Health and Human Services (HHS), applies to health insurance issuers (i.e., health insurers) providing individual and group health coverage, and self-insured governmental plans.[49]
- Title I, Part 7 of ERISA, administered by the U.S. Department of Labor, regulates health coverage provided by private-sector employers.[50] ERISA applies to insured and self-insured group health plans, as well as insurance issuers providing group health coverage. Part 7 of ERISA does not apply to governmental or church plans.[51]
- The IRC, administered by the U.S. Department of the Treasury, covers employment-based group health plans, including church plans, and health insurance issuers offering group health coverage. The IRC does not apply to health insurance issuers offering coverage in the individual market.[52]

While the Secretaries of HHS, Labor, and the Treasury coordinate enforcement efforts with respect to violations of the private health insurance market reforms,[53] enforcement mechanisms are different under each of the three statutes.

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[46] *See id*.

[47] *See* 42 U.S.C. § 1320b-5 note; 42 U.S.C. § 300gg-13 note.

[48] See id. For more information on federal health insurance requirements related to COVID-19, see CRS Report R46359, *COVID-19 and Private Health Insurance Coverage: Frequently Asked Questions*, by Vanessa C. Forsberg.

[49] *See* 42 U.S.C. § 300gg-21(a).

[50] *See* 29 U.S.C. § 1003(a).

[51] *Id*. § 1003(b). A "governmental plan" generally means a plan established or maintained for its employees by federal, state, or local governments. *See id*. § 1002(32). A church plan generally includes employee benefit plans "established and maintained . . . by a church," as well as plans maintained by certain church-associated entities. *See id*. § 1002(33). *See also generally* Advoc. Health Care Network v. Stapleton, 137 S. Ct. 1652, 1656 (2017) (examining ERISA's definition of church plan and remarking that it is "a mouthful, for lawyers and non-lawyers alike").

[52] 26 U.S.C. § 9831.

[53] *See* Pub. L. No. 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. 70,164 (Dec. 15, 1999).

PHSA

In general, the private health insurance requirements of Title XXVII of the PHSA apply to health insurance issuers in the group and individual markets and to self-funded, nonfederal governmental group plans.[54] With respect to health insurance issuers, the PHSA maintains an approach deferential to state governments, giving states the option to be the primary enforcers of the federal private health insurance requirements.[55] However, if the HHS Secretary determines that a state has failed to "substantially enforce" PHSA requirements with respect to health insurance issuers in the state, the Secretary must enforce the relevant federal provisions.[56] While the PHSA does not specify what a state must do to "substantially enforce" the federal private health insurance standards, regulations outline the process the Agency follows in determining whether federal enforcement is needed.[57] Pursuant to this process, should HHS receive information about a potential deficiency in state PHSA enforcement, the Agency notifies state officials, giving officials an opportunity to address the issue without further federal involvement.[58] Following this notice, if a state fails to correct an alleged enforcement failure, the Agency will inform the state that the Agency will assume enforcement responsibilities.[59]

The Secretary may impose a civil monetary penalty on insurance issuers that fail to comply with the PHSA's requirements. The maximum penalty imposed under the PHSA is currently $162 per day for each individual with respect to which such a failure occurs.[60] In determining the amount of the penalty, the Secretary must take into account an issuer's previous record of compliance with the PHSA's provisions and the severity of the violation.[61] 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 by exercising reasonable diligence would have known) that the violation existed.[62] If the violation was due to reasonable cause and not willful neglect, a penalty would not be imposed if the violation were corrected within thirty days of discovery.[63] Entities found to violate the PHSA's requirements may challenge the penalty in a hearing subject to a decision by an

[54] 42 U.S.C. § 300gg-21(a)(1).

[55] *Id.* § 300gg-22(a)(1). *See also* Sara Rosenbaum, *Can This Marriage Be Saved? Federalism and the Future of U.S. Health Policy under the Affordable Care Act*, 15 MINN. J.L. SCI. & TECH. 167, 174–84 (2014).

[56] 42 U.S.C. § 300gg-22(a)(2). According to the HHS, while the vast majority of states are enforcing ACA's health insurance market reforms, some states have indicated they lack authority to enforce them, or are otherwise not taking enforcement actions. Specifically, as of January 1, 2016, Missouri, Oklahoma, Texas, and Wyoming have notified the Agency they do not have the authority to enforce or are otherwise not enforcing ACA's insurance market reform provisions. *See Compliance and Enforcement: Ensuring Compliance with the Health Insurance Market Reforms*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Market-Reforms/compliance.html. *See also generally* Katie Keith, Kevin W. Lucia, & Sabrina Corlette, *Implementing the Affordable Care Act: State Action on the 2014 Market Reforms*, http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/1662_Keith_implementing_ACA_state_action_2014_reform_brief_v2.pdf.

[57] *See* 45 C.F.R. §§ 150.209–150.219.

[58] *See id.* § 150.211.

[59] *Id.* § 150.219.

[60] 42 U.S.C. § 300gg-22(b)(2)(C)(i). The civil monetary penalty for violations of Title XXVII of the PHSA is adjusted annually for inflation. *See* 45 C.F.R. § 102.3.

[61] 42 U.S.C. § 300gg-22(b)(2)(C)(ii).

[62] *Id.* § 300gg-22(b)(2)(C)(iii)(I).

[63] *Id.* § 300gg-22(b)(2)(C)(iii)(II).

administrative law judge.[64] Following this administrative hearing, entities may file an action for judicial review.[65]

With respect to state and local governmental plans, the HHS Secretary is the primary enforcer of the PHSA's requirements. Prior to ACA, state and local governments could elect to exempt their plans from PHSA's requirements.[66] However, this election is not applicable to the provisions added to the PHSA by ACA.[67] Accordingly, governmental plans are subject to ACA's private health insurance market reforms, and the HHS Secretary may impose a civil monetary penalty in cases where these plans fail to comply with these requirements.[68]

ERISA

Title I, Part 7 of ERISA applies to private-sector, employment-based group health plans, as well as health insurance issuers providing health insurance coverage in connection with these plans.[69] Unlike the PHSA and the IRC, Section 502(a) of ERISA authorizes plan participants and other individuals to bring various civil actions against group health plans and health insurance issuers.[70] 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 plan's terms, or to enforce or clarify the plaintiff's rights under the plan's terms.[71] Under this section, if a plaintiff's claim for benefits is improperly denied, the plaintiff may sue to recover the unpaid benefit.[72] Additionally, Section 502(a)(3) of ERISA permits participants to bring a civil action to enjoin any act or practice that violates ERISA or a plan's terms, or obtain "other appropriate equitable relief"[73] due to an ERISA violation.[74] Although not an explicit ERISA requirement, courts commonly find that plaintiffs must exhaust a plan's internal claims resolution procedures prior to seeking judicial review, particularly in cases involving a claim for benefits or a denied benefit.[75]

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[64] *Id.* § 300gg-22(b)(2)(D).

[65] *Id.* § 300gg-22(b)(2)(E).

[66] *Id.* § 300gg-21(a)(2)(A).

[67] *Id.* § 300gg-21(a)(2)(E).

[68] *Id.* § 300gg-22(b)(2)(A).

[69] 29 U.S.C. §§ 1181–1191c.

[70] *Id.* § 1132(a).

[71] *Id.* § 1132(a)(1)(B).

[72] *See id.*

[73] Courts sometimes determine whether the relief a plaintiff seeks is legal or equitable. 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-W. 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 213. 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 equitable relief under ERISA has been the subject of debate. *See generally* Dana Muir, *From Schism to Prism: Equitable Relief in Employee Benefit Plans*, 55 AM. BUS. L.J. 599 (2018). While there is no longer this divided court system, courts may still evaluate a claim based on this dichotomy. *See generally, e.g.*, Liu v. Sec. & Exch. Comm'n, 140 S. Ct. 1936 (2020); U.S. Airways, Inc. v. McCutchen, 569 U.S. 88 (2013).

[74] 29 U.S.C. § 1132(a)(3).

[75] ERISA requires employee benefit plans to provide an internal claims procedure for appealing denied benefits. *See id.* § 1133. *See also* 42 U.S.C. § 300gg-19 (incorporated by reference into ERISA).

In terms of monetary remedies, under ERISA, successful plan participants commonly may only receive the benefits the plaintiff would have been entitled to under the plan's terms.[76] Compensatory or punitive damages are not generally available under these ERISA provisions.[77] Further, the Supreme Court has found that Section 502(a) contains "exclusive" federal remedies, preempting state or common law causes of action that may provide for more generous remedies than those available under ERISA.[78]

The Secretary of Labor also may bring a civil suit against a group health plan's sponsor that violates ERISA's requirements.[79] Under ERISA, the Labor Secretary also has authority, among other things, to investigate alleged violations of Title I of ERISA,[80] as well as assess civil penalties in limited circumstances.[81]

IRC

Similar to ERISA, the private health insurance provisions in IRC Chapter 100 apply to employment-based group health plans and health insurance issuers providing group health coverage, but do not apply to governmental plans or the individual insurance market.[82] Under the IRC, the group health plan requirements are enforced through the imposition of an excise tax.[83] For single-employer plans, employers are generally responsible for paying this excise tax. Under multiemployer plans, the tax is imposed on the plan itself.[84]

A group health plan that fails to comply with the IRC's requirements may be subject to a tax of $100 per day for each affected plan participant during the noncompliance period.[85] Employers and other persons liable for the excise tax must self-report this obligation to the IRS or potentially face additional tax penalties and interest.[86] Assuming the failures to comply with the group health plan requirements "are due to reasonable cause and not to willful neglect," the excise tax is capped at the lesser of $500,000 or 10% of the aggregate amount that the employer pays or incurs

[76] *See, e.g.*, Mass. Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985)(Supreme Court explains that "the statutory provision explicitly authorizing a beneficiary to bring an action to enforce his rights under the plan -- § 502(a)(1)(B)… says nothing about the recovery of extracontractual damages.").

[77] *See, e.g., id*.; Mertens v. Hewitt Assocs., 508 U.S. 248, 251-63 (1993)(Court holds that Section 502(a)(3) of ERISA does not authorize lawsuits for monetary damages). *Cf.* Cigna v. Amara, 563 U.S. 421, 444-45 (2011)(equitable remedy of surcharge permissible under ERISA Section 502(a)(3)).

[78] *See, e.g.*, Aetna Health Inc. v. Davila, 542 U.S. 200, 209 (2004) (in a case involving patient injuries allegedly stemming from a denial of plan benefits, Court states that "any state-law cause of action that duplicates, supplements, or supplants the ERISA civil enforcement remedy conflicts with the clear congressional intent to make the ERISA remedy exclusive and is therefore pre-empted").

[79] *See, e.g.*, 29 U.S.C. § 1132(a)(5). However, in large part, the Secretary may not sue or take other enforcement action against health insurance issuers. *See id.* § 1132(b)(3).

[80] *See id.* § 1134.

[81] *See, e.g., id.* § 1132(b)(10) (relating to improper use of genetic information with respect to plan benefits).

[82] 26 U.S.C. §§ 9801–9834.; *id*. § 9831(a).

[83] *Id*. § 4980D.

[84] *Id*. § 4980D(e).

[85] The noncompliance period begins on the date when the failure first occurs, and ends on the date the failure is corrected. *Id.* § 4980D(b)(2). This excise tax may be higher in cases where an employer is subject to an IRS audit, the relevant group health plan violations are not corrected before a notice of examination for tax liability is sent to the employer, and these violations occur or continue during the period under examination. *See id.* § 4980D(b)(3).

[86] *See, e.g., id*. § 6621.

during the preceding taxable year for group health plans.[87] Additionally, in cases where the group health plan failures are unintentional, the Treasury Secretary may completely or partially waive the excise tax to the extent that payment of the tax would be excessive relative to the plan failure.[88]

Other limitations on the excise tax may apply. For instance, the excise tax does not apply if a failure is due to reasonable cause and not willful neglect, and the responsible party corrects the failure within a specified time frame.[89] In addition, small employers are exempt from paying the excise tax under specified circumstances.[90]

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

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

Statute	Application	Enforcement
Public Health Service Act, Title XXVII	Health insurance issuers offering group and individual coverage; self-insured governmental plans	States have primary enforcement responsibility against health insurance issuers; HHS Secretary can impose civil monetary penalties
Employee Retirement Income Security Act, Title I, Part 7	Group health coverage (including self-insured plans) of private-sector employers; ERISA does not apply to governmental plans or church plans	Secretary of Labor/employee right to sue
Internal Revenue Code, Chapter 100	Group health coverage (including self-insured plans) of private-sector employers, including church plans	Excise tax of $100 per day for each affected plan participant during the noncompliance period

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[87] *Id.* § 4980D(c)(3).

[88] *Id.* § 4980D(c)(4).

[89] *Id.* § 4980D(c)(2).

[90] *Id.* § 4980D(d). This section provides an exception to the excise tax for a plan of a small employer providing health coverage solely through a contract with a health insurance issuer if the failure is solely because of the health insurance coverage offered by the issuer. *Id.* § 4980D(d)(1). In general, a small employer is one that employed an average of at least two but no more than fifty employees on business days during the preceding calendar year and that employs at least two employees on the first day of the plan year. *Id.* § 4980D(d)(2).

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