

HOW PRIVATE HEALTH COVERAGE WORKS: A PRIMER 2008 UPDATE

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3. Regulation of Private Health Coverage

This section describes the basic regulatory framework for private health coverage under state and federal laws.

Understanding how private health coverage is regulated is complicated by the overlapping state and federal requirements for health coverage arrangements. States generally regulate the business of insurance, including health insurance. States license entities that offer private health coverage and have established laws that control the legal structure of insurers, their finances, and their obligations to the people that they insure. At the same time, a number of federal laws also regulate private health coverage. The most important of these laws, the Employee Retirement Income Security Act of 1974 (ERISA), establishes standards for employee benefit plans (including benefit plans providing medical care) established or maintained by an employer or an employee organization (i.e., a union). Since the vast majority of Americans with private health coverage receive it through employee benefit plans, understanding the interaction between federal and state laws is essential to understanding how private health coverage operates.

Unfortunately, this interaction is messy. In some cases, ERISA requirements coexist with state law and, in other cases, ERISA requirements preempt state law. And, precisely when ERISA preempts state laws is still the matter of much litigation, even though ERISA was passed over 30 years ago. Important interactions between state and federal law also occur under the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This section begins with a general description of how states regulate health insurance and continues with a general description of the applicable provisions of ERISA and HIPAA and their interaction with state law and state oversight of state-licensed health insuring organizations.

State Regulation of Health Insurance

The regulation of insurance has traditionally been a state responsibility. In 1945, Congress enacted the McCarran-Ferguson Act,^{iv} which clarified federal intent that states have the primary role in regulating the business of insurance.²

² The McCarran-Ferguson Act was enacted in response to the U.S. Supreme Court's decision in *United States v. South-Eastern Underwriters Assn.*, 322 U.S. 533 (1944), which held that insurers that conducted a substantial part of their business across state lines were engaged in interstate commerce and thereby were subject to federal antitrust laws. State and industry concern over the effect of the decision on state authority over insurance lead Congress to pass the McCarran-Ferguson Act to restore the primary role of states in regulating the business of insurance. See *United States Department of Treasury v. Fabe*, 508 U.S. 491, 499 (1993).

State regulation of health and other insurance starts with the licensing of entities that sell insurance within the state. The licensing process reviews the finances, management, and business practices of the insuring entity to evaluate whether it can provide the coverage that is promised to policyholders. States establish requirements for state-licensed health insuring organizations in a number of areas to protect the people that they cover. States also license the insurance producers (e.g., agents, brokers) who sell health insurance within the state.

The discussion below describes the types of insurance laws that states have typically enacted, though the content and extent of regulation in these areas varies among the states, sometimes significantly.

Minimum capital requirements: *These are requirements of state law that set a minimum amount of net worth that an insuring organization must have in order to operate. This minimum amount must be unencumbered – i.e., it must be available to pay for claims. The amount varies with the type of insurance that is being sold by the insurer (e.g., life, health, auto, workers compensation). Relatively recent state laws establishing "risk-based" capital requirements relate minimum capital requirements to insurers' risk exposure and business practices. For example, an HMO may have lower minimum capital requirements than an indemnity health insurer because the HMO has additional tools to manage risk.*

Financial Standards

State financial standards include requirements for minimum capital, investment practices, and the establishment of claims and other reserves. States require state-licensed health insuring organizations to submit quarterly and annual financial statements, and also perform periodic on-site financial examinations to ensure that state-licensed health insuring organizations remain financially viable.

Market Conduct

State market conduct standards include requirements relating to claims practices, underwriting practices, advertising, marketing (including licensing of insurance producers), rescissions of coverage, and timely payment of claims. States generally have laws giving them authority to address unfair trade and unfair claims practices, and perform periodic market conduct examinations of state-licensed health insuring organizations to review business practices.

Guaranty fund: *This is a funding mechanism established under state law to pay the claims of insurers that become insolvent. The funds to pay claims generally are provided by assessing other insurers that provide coverage in the state.*

Policy Forms

Policy forms are the pieces of paper that establish the contractual relationship

Policy form: *This is a representative contract of the policies that health insuring organizations offer to policyholders. Health insuring organizations will have different policy forms representing different configurations of benefits and different types of customers (e.g., individuals or small groups). In some states, health insuring organizations have to file the policy forms that they offer to certain types of customers with the insurance department.*

between the health insuring organization and the purchaser. State standards for policy forms address the content of the form -- including required and prohibited contract provisions and standard definitions and terminology -- as well as how they are issued to purchasers. In some cases, states review or approve policy forms, although these practices vary by type of purchaser and by state.^v States most often review or approve policies that are offered directly to consumers or to

small employers; larger purchasers are presumed to be sophisticated buyers that need less protection.

Access to Coverage and Required Benefits

State standards relating to access address when, and on what terms, state-licensed health insuring organizations must accept an applicant for coverage. Most states have laws that require state-licensed health insuring organizations to provide coverage to small employers that want it, with some limitation on the rates that can be charged (e.g., restrictions on how premiums can vary based on age and health status). Fewer states apply these types of rules to the individual insurance market, where people buy coverage on their own rather than through an employer. Federal law also includes requirements for access to coverage, as discussed under HIPAA below.

Guaranteed issue or guaranteed availability of coverage: *This is a requirement that insurers accept specified applicants for coverage, generally without regard to their health status or previous claims experience. For example, health insuring organizations generally are required by state and federal law to issue coverage to small employers that apply. Separate provisions of law generally address the extent to which health insuring organizations can vary premiums based on health status, claims experience, or other factors.*

All states also have laws that require state-licensed health insuring organizations selling health coverage to offer or include coverage for certain benefits or services (known as “mandated benefits”), including items such as mental health services, substance abuse treatment, and breast reconstruction following mastectomy. The number and type of these mandates varies considerably across states. Federal law also includes certain mandated benefits, as discussed under HIPAA below.

State standards also address the ability of state-licensed health insuring organizations to offer restricted coverage to people with preexisting health problems. As discussed above, health coverage providers generally exclude benefits for a defined period of time for treatment of medical conditions that they determine to have existed within a specific period prior to the beginning of coverage. States set standards for how these limitations can be structured, and generally limit the application of such exclusions under group policies when people are switching from one health coverage to another (often called “portability” protection). Federal law also ensures this type of portability, as discussed under HIPAA below.

Premiums

State standards for premiums address the cost of insurance to consumers, both initially and when coverage is renewed. The degree of regulation varies by type of purchaser and by state. For health coverage offered directly to individuals, many states establish minimum loss ratios (the percentage of premium that must be paid out in claims rather than for administrative costs or profits) and also reserve the right to review or approve the rates submitted by state-licensed health insuring organizations.^{vi} State standards generally require that rate variations (e.g., variations due to age, gender, location) be actuarially fair (meaning that they are based on true variations in health costs). Some states further limit the rights of insurers to vary premiums for individual policyholders by age or health status (often referred to as “rate band” or “community rating”). Health coverage sold to small employers also is regulated, but the regulation tends to focus more on limiting the extent to which the rates offered to a small employer can reflect the claims experience or health status of workers in the group.

Loss ratio: *This is the ratio of benefits paid to premiums. Loss ratios can be calculated for a particular policy form, for a line of business (e.g., small group health insurance), or a health insuring organization's overall business. Minimum loss ratios for established by law or regulation typically apply to a policy form.*

Rate bands: *These are laws that restrict the difference between the lowest and highest premium that a health insuring organization may charge for the same coverage. For example, a rate band may specify that the highest rate a health insuring organization may charge for a policy may be not more than 150 percent of the lowest rate charged for the same policy. The rate bands may limit all factors by which rates vary (e.g., age, gender), or may apply only to specified factors, such as health status or claims experience.*

Community rating: *This is a rating method under which all policyholders are charged the same premium for the same coverage. "Modified community rating" generally refers to a rating method under which health insuring organizations are permitted to vary premiums for coverage based on specified demographic characteristics (e.g., age, gender, location) but cannot vary premiums based on the health status or claims history of policyholders.*

Renewability

Health coverage is generally provided for a limited period (typically one year),

Guaranteed renewability: *This is a provision of an insurance policy or law which guarantees a policyholder the right to renew their policy when the term of coverage expires. The health insuring organization generally is permitted to change the premium rates at renewal.*

and state requirements address the extent to which a purchaser has a right to renew the policy for another year without being reevaluated for coverage. Federal law also is important in this area, and is discussed under HIPAA, below.

State standards also address the ability of individuals covered under group policies to continue coverage if the group policyholder cancels the coverage or the person is no longer part of the group. Standards in some states permit these people to continue coverage or to convert to individual insurance in some instances. The requirements for terms of coverage and rates vary substantially across states. Federal law (often referred to as “COBRA” continuation) provides similar protection to individuals with employer-sponsored coverage, as discussed under ERISA, below.

HMOs, Managed Care, and Network Arrangements

States for many years have had separate standards for HMOs, recognizing their dual roles as providers and insurers of health care. State HMO standards, in addition to addressing typical insurance topics such as finances, claims administration, policy forms, and minimum benefits, also establish standards that affect HMOs as entities that directly deliver health care and closely manage the health care use of those they insure. Such state standards include requirements relating to the establishment of utilization review and quality assurance programs, the establishment of enrollee grievance processes, and the contents of contracts with participating health care providers.

As the use of managed care has proliferated among non-HMO state-licensed health insuring organizations (e.g., insurers offering PPO-type coverage), and as managed care practices have become more controversial with the general public, states have extended HMO-type standards to other entities offering managed care and have generally increased their regulatory scrutiny in this area. Standards relating to network adequacy (e.g., the number, location, and types of physicians), utilization review practices, credentialing of participating health care providers, and quality assessment and improvement have recently been adopted in a number of states.

Complaints, Remedies, and Appeals

States also have laws and regulations that assist people who do not receive the benefits that they believe are covered under their health plans. States receive consumer complaints, and in some cases are able to act as intermediaries to resolve specific conflicts between consumers and health coverage providers. The receipt of a

large number of complaints about a particular health coverage provider also may alert regulators to more pervasive market conduct abuses and trigger a broader review of marketing or claims practices.

State law also generally permits people who feel aggrieved by a state-licensed health coverage provider to seek redress through a lawsuit. Such suits may be brought under the contract for coverage, tort, or in some cases under special state insurance laws (such as unfair claims practices laws). For example, HMOs and other managed care arrangements may be sued under state medical malpractice laws if their delivery of health care does not meet ordinary standards of care. Under state law, a person covered by a health insurance policy also generally can sue the insurer if benefits are not delivered as promised and the failure to deliver the benefits was negligent and the proximate cause of the person's injury. In some cases where the aggrieved person is covered under an employee benefit plan, however, ERISA preempts the person's right to bring certain types of lawsuits. This interaction between state and federal law is discussed in more detail under ERISA, below.

In the last few years, most states have adopted standards that provide for an independent, external party to review certain benefit decisions made by state-licensed health coverage providers. For example, these states permit a covered person to appeal a decision by a health coverage provider that denies a benefit because it was not medically necessary or because it was experimental. The types of claims that are subject to review, who the reviewers are, and the procedures for requesting a review vary substantially across the states. There also is a question as to whether ERISA preempts state external appeal laws as they apply to benefit decisions for people covered under an employee benefit plan (as discussed under ERISA, below).

Federal Laws Governing Health Insurance

Although the business of insurance is primarily regulated by the states, a number of federal laws contain requirements that apply to private health coverage, including ERISA, HIPAA, the Americans with Disabilities Act, the Internal Revenue Code, the Civil Rights Act, the Social Security Act (relating to private coverage that supplements Medicare), and the Gramm-Leach-Bliley Act (relating to financial services and bank holding companies). The discussion below focuses on two of these laws, ERISA and HIPAA, because of the significant impact that they have on the structure of private health coverage. Other Federal laws that affect private health coverage are then discussed.

ERISA (Employee Retirement Income Security Act)

ERISA^{vii} was enacted in 1974 to protect workers from the loss of benefits provided through the workplace. The requirements of ERISA apply to most private employee benefit plans established or maintained by an employer, an employee organization (such as a labor union), or both (referred to here generally as "plan

sponsors”). Employee benefit plans that provide medical benefits (and other non-pension benefits) are referred to as “employee welfare benefit plans.”

ERISA does not require employers or other plan sponsors to establish any type of employee benefit plan, but contains requirements applicable to the administration of the plan when a plan is established. Thus, employers remain essentially free to decide if they want to offer health benefits at all and, if so, what level of benefits and the amount of coverage they will provide.

The important requirements for employee welfare benefit plans include:

Written document. ERISA requires that an employee benefit plan be

***Fiduciary:** This generally refers to a person who manages funds or benefits for another. A fiduciary acts in a position of trust and generally is required to act in the best interests of the beneficiary. Under ERISA, a fiduciary is a person who exercises discretion or control in the management of an employee benefit plan or in the management or disposition of the assets of an employee benefit plan.*

established and maintained pursuant to a written document, which must provide for at least one “named fiduciary” who has authority to manage and administer the plan.

Disclosure requirements. ERISA requires the administrator of an employee welfare benefit plan to provide a summary plan description (SPD) to people covered under the plan (called participants and beneficiaries). The SPD must clearly inform participants and beneficiaries of their benefits and obligations under the plan and of their rights under ERISA. The SPD must include information about how to file a claim for benefits and how a denial of a claim can be appealed.

Reporting requirements. ERISA requires administrators of certain employee benefit plans to file annual reports describing the operations of the plan. Reports are filed with the Internal Revenue Service, which forwards the information to the Department of Labor. Certain types of employee welfare benefits plans (e.g., those with fewer than 100 participants and are self-funded, fully insured, or both) are not required to file a report.

Fiduciary requirements. ERISA establishes standards of fair dealing for “fiduciaries” who exercise discretion or control in the management of an employee benefit plan or in the management or disposition of the assets of an employee benefit plan. ERISA fiduciaries may be corporate entities or individuals and may include, for example, plan trustees, plan administrators, or members of a plan’s investment committee. ERISA requires that employee benefit plans have at least one “named fiduciary” who is responsible for

administration and operation of the plan. The plan documents may designate additional fiduciaries.

ERISA requires plan fiduciaries to carry out their responsibilities “solely in the interest of (plan) participants and beneficiaries and for the exclusive purpose of providing benefits . . . and defraying reasonable expenses of administering the plan.”^{viii} ERISA also requires plan fiduciaries to act with the same skill, care, prudence, and diligence that a prudent person would use in like circumstances, and to carry out their responsibilities in accord with the lawful provisions of the plan documents.

Claims for benefits. ERISA requires employee benefit plans to maintain procedures for claiming benefits under the plan and to inform participants and beneficiaries of the procedures. Employee benefit plans must also have a procedure permitting participants and beneficiaries to appeal a denial of benefits to a fiduciary. Department of Labor regulations made substantial changes to requirements for these procedures, including minimum standards for claims procedures, processes for appeal of denied claims, timeframes for plans to make decisions on claims for benefits and on appeals of denials of claims, and greater disclosure of information by insurers to claimants, effective for plan years after July 2002.^{ix}

Remedies and enforcement. ERISA contains civil enforcement provisions that permit participants and beneficiaries to bring actions to obtain benefits due to them under an employee benefit plan, for redress of fiduciary breaches, to stop practices that violate ERISA or the provisions of the employee benefit plan, or for other appropriate equitable relief. Courts may award reasonable costs and attorney fees to participants and beneficiaries who prevail. ERISA does not, however, provide a remedy to recover economic or non-economic (e.g., pain and suffering) damages that may result from improper claims denials, fiduciary breaches, or other improper acts. ERISA also contains other civil and criminal penalties for violations of its provisions.

Continuation coverage. As amended by the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), ERISA requires plan sponsors that employ 20 or more employees to offer continuation coverage to qualified beneficiaries (including dependents) who lose health coverage under an employee benefit plan for certain specified reasons (e.g., death of an employee, termination of employment, divorce, or legal separation). ERISA requires the plan sponsor to notify individuals of their right to continuation coverage and addresses the benefits that must be offered, the period that qualifying individuals are eligible for continuation coverage, and premium that they must pay.

ERISA Interaction With State Law

How ERISA interacts with state law is quite complex and has generated numerous court cases which, in the absence of clarifying federal legislation, have determined whether federal or state law pertains to employee benefit plans. As a general matter, ERISA preempts state laws that would regulate the operation of employee benefit plans, affecting several aspects of the regulation of these plans.

ERISA contains an express provision that preempts state laws that “relate to” an employee benefit plan.^x In applying the term “relates to,” courts have looked to whether the state law in question has a “connection with or reference to” an employee benefit plan.^{xi 3} For example, state laws that prohibited garnishment of benefits provided under an employee benefit plan or that required employers to maintain existing health coverage for employees who are eligible for workers compensation benefits have been found to be preempted by ERISA.^{xii} State laws of general applicability, however, are not preempted merely because they impose some burdens on an ERISA plan. For example, a state law that imposes a surcharge on hospitals bills was found not to be preempted as applied to hospitals owned by an employee benefit plan.^{xiii}

The ERISA preemption provision has an exception that saves from preemption those state laws that regulate insurance. This “saving” provision permits states to continue to apply their insurance laws to insurers, including state-licensed health insuring organizations, even when they provide coverage to or under an employee benefit plan. State insurance laws can be saved because, in the case of plans that buy insurance as opposed to self funding, the state laws regulate the insurance products sold to the ERISA plans, rather than the plans themselves.

The saving clause thus allows states to set standards for ERISA-governed employer-sponsored health benefits in those situations in which employers buy health insurance rather than buying just the administrative services of a health benefits services company for their self-funded plans. For example, state laws that mandate the inclusion of certain benefits in health insurance contracts are saved from preemption, even though application of the law affects the benefits provided under an employee benefit plan.^{xiv} Similarly, a state insurance law that prohibits insurers from automatically denying a claim for benefits because it is not filed in a timely manner is saved from preemption because the law regulates insurance, even though the application of the law affects the administration of an employee benefit plan.^{xv} A state law requiring managed care plans to permit all willing providers to participate in their networks is saved from preemption by applying the standards of whether the state law is specifically directed toward the insurance industry and whether it substantially affects the risk-pooling

³ The U.S. Supreme Court expressed concern about the unhelpful nature of the preemption language in ERISA, and has stated that in looking at whether a state law is preempted it “must go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive.” *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurer. Co.*, 514 U.S. 645, 656 (1995).

arrangement between the insurer and the insured.^{xvi} State laws that simply apply to insurers, however, but which do not primarily regulate the business of insurance, are not saved from preemption.

Although the ERISA preemption provision saves state laws that regulate insurance, ERISA prohibits states from “deeming” employee benefit plans to be insurers. This provision prohibits states from treating employee benefit plans (i.e., self-funded employee plans) as insurers and attempting to regulate them directly under their insurance laws.^{xvii}

As a practical matter under ERISA, states can continue to regulate the insurance activities of state-licensed health insuring organizations that provide health coverage to an employee benefit plan established by an employer or other plan sponsor. States generally cannot, however, regulate the content or activities of self-funded employee benefit plans. States also cannot indirectly regulate the practices of employee benefit plans by trying to regulate how third parties, including state-licensed health insuring organizations, provide administrative services to self-funded employee benefit plans. As an example, states can require insurance companies and HMOs to include coverage for specified benefits (e.g., mental health services) in the policies they sell. Any employer or individual purchasing insurance coverage would therefore have to purchase a policy that included those benefits. States cannot, however, require self-funded employer plans to offer any specified benefits.

Another area of ERISA preemption involves the civil remedies available to participants and beneficiaries relating to a claim for benefits. As discussed above, ERISA provides a limited set of civil remedies to participants and beneficiaries. The courts have determined that these remedies are the exclusive remedies available to participants and beneficiaries to contest a denial of benefits under an employee benefit plan. State laws that provide for causes of action against the administrator or another fiduciary of an employee benefit plan (e.g., for breach of contract or tort) are preempted if they could have been brought under the civil enforcement provisions of ERISA.^{xviii} The Supreme Court has determined 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.”^{xix xx}

HIPAA (Health Insurance Portability and Accountability Act)

A second federal law that established important regulatory requirements for private health coverage is HIPAA, enacted in 1996. HIPAA was motivated by concern that people face lapses in coverage when they change or lose their jobs. As discussed above, health coverage providers often exclude benefits for preexisting health conditions for new enrollees. HIPAA also addressed other concerns of federal policymakers about private health coverage.

HIPAA and related standards address several areas, including: portability, access to coverage, renewability, nondiscrimination, and mandated benefits. The standards established by HIPAA vary by market segment (e.g., large group, small group, or individual coverage) and by type of coverage provider. HIPAA creates separate but similar standards for state-licensed health insuring organizations and employee welfare benefit (i.e., ERISA) plans. Generally, the provisions applicable to employee welfare benefit plans and plan sponsors are incorporated into ERISA and into the Internal Revenue Code, and the provisions applicable to state-licensed health insuring organizations are incorporated into the Public Health Service Act. In addition, the HIPAA standards that create individual rights (e.g., portability) and that are applicable to state-licensed health insuring organizations providing health coverage to employee benefit plans also are incorporated into ERISA and the Internal Revenue Code. Three federal agencies – the U.S. Departments of Labor, Health and Human Services, and Treasury -- coordinate rulemaking under HIPAA.^{xxi}

Preexisting condition exclusions and portability. As discussed above, some private health coverage excludes benefits for treatment of preexisting medical conditions for defined period of time after initial enrollment. HIPAA requires state-licensed health insuring organizations providing group coverage and employee welfare benefit plans providing health benefits to limit preexisting condition exclusion periods to no more than 12 months (18 months for late enrollees unless they enroll under special circumstances). The preexisting condition exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 months before the enrollment date. For eligible individuals leaving group coverage for another group plan, any preexisting condition exclusion period must be reduced by the number of days that a newly enrolling person was previously covered by public or private health coverage; the time between lapse of the previous coverage and enrollment in the new coverage must be shorter than 63 days.

Access to coverage. HIPAA requires state-licensed health insuring organizations to make all of their small group products available to any qualifying small employer that applies, regardless of their claims experience or of the health status of their employees. Under HIPAA, a small employer is defined as having 2 to 50 employees. HIPAA does not have standards for the premium that can be charged to small employers seeking coverage, although, as discussed above, most states have laws that limit rate variation in the small group market.

HIPAA also requires state-licensed health insuring organizations to accept certain people leaving group health coverage for coverage in the individual market regardless of their health status and without any exclusion period for preexisting medical conditions. To be eligible, the person must not be eligible for other public or private group health coverage, must have been previously covered for a period of at least 18 months, must apply for the individual coverage within 63 days of leaving the group coverage, and must have exhausted any federal or state continuation rights under their group policy. States are provided substantial

flexibility in determining the mechanism for making coverage available to eligible people. For example, in most states, eligible people are guaranteed access to coverage in the state's high-risk pool; private insurers are not required to sell coverage to them. HIPAA generally does not regulate the premiums that people can be charged for the coverage that is offered under HIPAA.^{xxii}

Renewability. HIPAA requires state-licensed health insuring organizations and certain employee benefit plans that provide benefits to multiple employers to guarantee that the coverage can be renewed at the end of the period of coverage. This protection generally means that group (either small or large) or individual coverage cannot be terminated by the health coverage provider except in cases such as nonpayment of premium and fraud. HIPAA, however, does not have standards for the premiums that may be charged at renewal.

Nondiscrimination. HIPAA prohibits state-licensed health insuring organizations providing group coverage and employee welfare benefit plans providing health benefits from considering the health status of a member of the group in determining the member's eligibility for coverage, premium contribution, or cost-sharing requirements. Final 2006 rules clarified the exception for wellness programs (programs of health promotion or disease prevention), specifying the circumstances under which wellness programs can discriminate based on health status-related factors.^{xxiii} A more recent clarification provided that supplemental coverage (including benefits under a wellness program, such as a reduced premium for nonsmokers) cannot discriminate on the basis of health factors unless specified criteria are met.^{xxiv}

HIPAA was structured in a way that reasonably clearly delineates the state and federal roles in enforcing its standards. As described above, HIPAA standards applicable to employee welfare benefit plans and plan sponsors are incorporated into ERISA and the Internal Revenue Code, and are enforced by the U.S. Departments of Labor and Treasury. Standards applicable to state-licensed health insuring organizations generally are incorporated into the Public Health Services Act, and are under the jurisdiction of the U.S. Department of Health and Human Services (DHHS).⁴ HIPAA provides however, that if a state's law establishes standards for state-licensed health insuring organizations that are at least as stringent as the HIPAA standard, the state is the primary enforcer of the standard, with DHHS having authority to enforce the standard if the state does not. Where a state's laws do not contain a standard at least as stringent as the HIPAA standard, enforcement falls to DHHS.

⁴ As discussed above, standards for some HIPAA provisions applicable to state-licensed health insuring organizations providing coverage to employee benefit plans also are incorporated in ERISA, and individuals may bring actions under ERISA to enforce those standards.

Although HIPAA establishes generally clear federal and state enforcement responsibilities, in practice there have been some difficulties. The test for when a state assumes enforcement responsibility is conducted separately for each different standard under HIPAA, which can lead to a patchwork of federal and state enforcement responsibilities.^{xxv} This is most problematic for federally-mandated benefits.

Other Federal Laws That Affect Private Health Coverage

Other federal laws require health coverage providers to cover certain benefits as part of their benefit arrangements. Although enacted separately from HIPAA, the following benefit requirements are incorporated into the same legal framework as the HIPAA standards, and include the following: (1) the Women's Health and Cancer Rights Act requires group health coverage providers that provide coverage for mastectomies to also cover breast reconstruction surgery following a mastectomy,^{xxvi} (2) the Newborns' and Mothers' Health Protection Act prohibits group health coverage providers from restricting hospital stays following childbirth to less than 48 hours (or 96 hours following delivery by cesarean section),^{xxvii} and (3) the Mental Health Parity Act restricts the ability of group health plans sponsored by employers with more than 50 employees to impose annual and lifetime dollar limits for mental health benefits that are more stringent than for medical and surgical benefits.^{xxviii} The Pregnancy Discrimination Act amends the Civil Rights Act to require that any health insurance an employer provides must cover expenses for pregnancy-related conditions on the same basis as costs for other medical conditions.^{xxix} The Americans with Disabilities Act also amends the Civil Rights Act to prohibit discrimination solely on the basis of disability; employers are prohibited from such discrimination in many job-related aspects including employee compensation; however, the Act's requirements for insurers and their insurance products are less clear, allowing insurers to classify, underwrite, or administer health risks based on sound actuarial principles or experience.^{xxx}

Endnotes

- ⁱ Kaiser Family Foundation, *The Uninsured—A Primer*, October 2007, Table 3, p. 32, <http://www.kff.org/uninsured/upload/7451-03.pdf>
- ⁱⁱ *Ibid.*
- ⁱⁱⁱ National Association of Insurance Commissioners, “Departmental Regulation of HMOs” in *Compendium of State Laws on Insurance Topics*, 2000.
- ^{iv} 15 U.S.C. 1011-1015.
- ^v National Association of Insurance Commissioners, “Filing Requirements Health Insurance Laws Forms and Rates” in *Compendium of State Laws on Insurance Topics*, 2000.
- ^{vi} *Ibid.*
- ^{vii} 29 U.S.C. 1001 *et seq.*
- ^{viii} 29 U.S.C. 1104(a).
- ^{ix} 29 C.F.R. 2560.503-1 (also see *Federal Register*, Vol. 65, No. 225, November 21, 2000, pp. 70246-70271, and *Federal Register*, Vol. 66, No. 131, July 9, 2001, pp. 35886-35888).
- ^x 29 U.S.C. 1144.
- ^{xi} *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96-97 (1983).
- ^{xii} *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992).
- ^{xiii} *De Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997).
- ^{xiv} *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).
- ^{xv} *Unum Life Insurer. Co. of Am. V. Ward*, 526 U.S. 358 (1999).
- ^{xvi} *Kentucky Assn. of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003).
- ^{xvii} *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1984).
- ^{xviii} *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987).
- ^{xix} *Cicio v. Does*, 385 F.3d 156 (2004), at 158, quoting *Aetna Health Inc. v. Davila*, 542 U.S. 200 (2004).
- ^{xx} The Supreme Court has determined that state insurance laws that allow participants in insured plans to appeal to external review bodies to get an independent opinion regarding a claim that was denied are considered not to create additional remedies beyond those allowed by ERISA and therefore are not preempted by ERISA (*Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002)). Participants seeking such independent reviews would still have rely on the remedies under ERISA if a plan did not comply with a reviewer’s external review determination.
- ^{xxi} The HIPAA provisions incorporated into ERISA may be found at 29 U.S.C. 1181 *et seq.*; the provisions incorporated into the Internal Revenue Code may be found at 26 U.S.C. 9801 *et seq.*; the provisions incorporated into the Public Health Service (PHS) Act may be found at 42 U.S.C. 300gg *et seq.* Regulations issued by the Departments of Labor, the Treasury, and Health and Human Services on group market provisions are contained in 29 C.F.R Part 2590, 26 C.F.R Part 54, and 45 C.F.R Parts 144 and 146; reforms provided in the PHS Act for the individual market are contained in 45 C.F.R Parts 144 and 148. For the most recent regulations on portability, see *Federal Register*, Vol. 69, No. 250 (December 30, 2004), 78720-78799, <http://www.dol.gov/ebsa/regs/fedreg/final/2004028112.pdf>; for the most recent rules on nondiscrimination and wellness programs, see *Federal Register*, Vol. 71, No. 239 (December 13, 2006), 75014-75055, <http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf>
- ^{xxii} General Accounting Office, *Health Insurance Standards: New Federal Law Creates Challenges for Consumers, Insurers, and Regulators*, GAO/HEHS-98-67 (February 1998) and *Private Health Insurance: Progress and Challenges in Implementing 1996 Federal Standards* (GAO/HEHS-99-100 (May 1999)10-16.
- ^{xxiii} *Federal Register*, Vol. 71, No. 239 (December 13, 2006), 75014-75055, <http://www.dol.gov/ebsa/regs/fedreg/final/2006009557.pdf>
- ^{xxiv} U.S. Department of Labor, Employee Benefits Security Administration, Field Assistance Bulletin No. 2007-04, “Supplemental Health Insurance Coverage as Excepted Benefits Under HIPAA and Related Legislation,” (December 7, 2007), <http://www.dol.gov/ebsa/pdf/fab2007-4.pdf>.
- ^{xxv} See General Accounting Office, *Implementation of HIPAA: Progress Slow in Enforcing Federal Standards in Nonconforming States*, GAO/HEHS-00-85 (March 2000) and *Private Health Insurance: Federal Role in Enforcing New Standards Continues to Evolve*, GAO-01-652R (May 7, 2001).
- ^{xxvi} The Women’s Health and Cancer Rights Act of 1998 (Title IX of P.L. 105-277).
- ^{xxvii} The Newborns’ and Mothers’ Health Protection Act of 1996 (Title VI of P.L. 104-204).
- ^{xxviii} The Mental Health Parity Act of 1996 (Title VII of P.L. 104-204, most recently extended by P.L. 109-432).
- ^{xxix} The Pregnancy Discrimination Act of 1978 (P.L. 95-555).
- ^{xxx} The Americans with Disabilities Act of 1990 (P.L. 101-336). See J. Mathis, Bazelon Center for Mental Health Law, “The ADA’s Application to Insurance Coverage,” June 2004, http://uacf4hope.org/index2.php?option=com_content&do_pdf=1&id=257.