Congressional Research Service

MEMORANDUM February 24, 2012

To: House Energy and Commerce Committee
Attention: Paul Edattel

From: Jennifer Staman and Jon Shimabukuro
Legislative Attorneys
American Law Division

Subject: **Enforcement of the Preventive Health Care Services Requirements of the Patient Protection and Affordable Care Act**

You have asked for an updated memorandum[1] addressing the consequences of non-compliance with a provision in the Patient Protection and Affordable Care Act (PPACA or ACA)[2] to provide coverage of preventive health services without cost sharing (e.g., a co-pay or a deductible).[3] In particular, you have asked whether a health plan that does not offer coverage for contraceptive services and is maintained by a religious entity that is not considered to be a "religious employer" under final rules issued by the Departments of Health and Human Services (HHS), Labor (DOL) and the Treasury (the Departments),[4] would be subject to penalties. As discussed below, assuming that a health plan is subject to the private health insurance reforms of ACA and is not a "grandfathered health plan" under ACA, a health plan established or maintained by a "religious employer", or an organization eligible for the temporary enforcement safe harbor described by the Departments, it seems possible that enforcement mechanisms found in Employer Retirement Income Security Act (ERISA), the Public Health Service Act (PHSA), and the Internal Revenue Code (IRC) could be applied to these non-compliant health plans. [5]

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[1] This memorandum is an update to a memorandum provided to you on February 8, 2012.

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

[3] P.L. 111-148, §1001, creating section 2713 of the Public Health Service Act.

[4] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621 (Aug. 3, 2011) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[5] It is important to note that health plans seeking to participate in an American Health Benefit Exchange and health insurers providing coverage in the individual and small group markets will be required to provide the "essential health benefits package" described in section 1302 of ACA. *See* P.L. 111-148, §§ 1201 (creating section 2707 of the Public Health Service Act), 1301(a)(1)(B). Section 1302(a) of ACA contains categories of benefits that must be offered as part of the essential health benefits package, and one category is "preventive and wellness services and chronic disease management." 42 U.S.C. §18022(b)(1)(I). HHS recently issued a bulletin with respect to its future approach in defining the essential health benefits package. *See* Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, Essential Health Benefits Bulletin, December 16, 2011, available at http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf. Additional HHS guidance indicates that the preventive services described in section 2713 of the PHSA will be a part of this package. *See* Department of Health and Human Services, Centers for Medicare & Medicaid
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Due to the general interest in this topic, CRS is receiving other requests on this issue. While this memorandum has been specifically tailored to your question, parts of this memorandum may be used or have been used to respond to other requesters.

Background

ACA, as amended, greatly expanded the scope of federal regulation over health insurance provided through employment based group health coverage, as well as coverage sold in the individual insurance market. Federal health insurance standards created by ACA require an extension of dependent coverage to age 26 if such coverage is offered; the elimination of preexisting condition exclusions; a bar on lifetime annual limits on the dollar value of certain benefits; and a prohibition on health insurance rescissions except under limited circumstances, among many other things.[6]

Section 2713 of the PHSA, as added by ACA and incorporated under section 715(a)(1) of ERISA and section 9815(a)(1) of the IRC, requires the provision of coverage for specified preventive health services without imposing any cost sharing requirements. Section 2713(a)(4) indicates that such services will include "with respect to women, such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration . . ."

Following the enactment of ACA, HHS commissioned the Institute of Medicine (IOM) to recommend preventive services that should be considered in the development of comprehensive guidelines. The IOM made its recommendations in a July 19, 2011 report.[7] Among the IOM's recommendations was coverage of "the full range of Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling for women with reproductive capacity."[8]

On August 1, 2011, the Departments published guidelines based on the IOM's recommendations.[9] The guidelines are supported by the Health Resources and Services Administration (HRSA).

Interim final regulations that address the coverage of preventive health services were first published in the *Federal Register* on July 19, 2010.[10] On August 3, 2011, in response to comments received about these

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Services, Frequently Asked Questions on Essential Health Benefits Bulletin, February 17, 2012, available at http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf. This memorandum does not address any potential issues associated with defining contraceptive services as an essential health benefit under ACA.

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

[7] *See* Inst. of Medicine, *Clinical Preventive Services for Women: Closing the Gaps* (2011), http://www.iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx.

[8] *Id*. at 109-110.

[9] *See* Health Resources & Services Admin., *Women's Preventive Services: Required Health Plan Coverage Guidelines* (2011), http://www.hrsa.gov/womensguidelines/.

[10] Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726 (July 19, 2010) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

regulations, an interim final rule that amended the July 19, 2010 regulations was published.[11] Most notably, the interim final rule provides HRSA with the authority to exempt "religious employers" from the preventive health services guidelines "where contraceptive services are concerned."[12] A definition for the term "religious employer" was added by the interim final rule:

> [A] "religious employer" is an organization that meets all of the following criteria:
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> (1) The inculcation of religious values is the purpose of the organization;
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> (2) The organization primarily employs persons who share the religious tenets of the organization;
>
> (3) The organization serves primarily persons who share the religious tenets of the organization; and
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> (4) The organization is a nonprofit organization as described in section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.[13]

This definition was criticized by some for being so narrow that many religious institutions that provide health, educational, or charitable services would likely not be considered religious employers for purposes of the exemption.[14] The Departments received over 200,000 comments on the amended interim regulations, with some commenters urging a broader definition for the term "religious employer."[15]

On February 15, 2012, the Departments published final rules on the coverage of contraceptive services.[16] The final rules provide for the adoption of the definition established in the August 3, 2011 interim final rule. In response to those who urged a broader exemption that would include religiously affiliated employers that may not qualify as "religious employers" under the definition, the Departments noted:

> A broader exemption . . . would lead to more employees having to pay out of pocket for contraceptive services, thus making it less likely that they would use contraceptives, which would undermine the benefits [of requiring coverage of contraceptive services without cost sharing].[17]

At the same time, however, the Departments provided for a temporary enforcement safe harbor for non-exempted, nonprofit organizations with religious objections to contraceptive coverage.[18] During the safe

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[11] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 Fed. Reg. 46,621 (Aug. 3, 2011) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[12] *Id*. at 46,623. Although the term "contraceptive services" is not defined in the interim final rule, the coverage guidelines supported by HRSA would seem to suggest that such services include "All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity." *See Guidelines*, *supra* note 9.

[13] *Id*. at 46,626. The definition is codified at 45 C.F.R. § 147.130(a)(1)(iv)(B).

[14] *See, e.g.*, U.S. Conf. of Catholic Bishops, *Background: The New Federal Mandate for Contraception/Sterilization Coverage* (Jan. 20, 2012), http://usccb.org/issues-and-action/religious-liberty/conscience-protection/upload/preventiveservicesbackgrounder-3.pdf.

[15] Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 77 Fed. Reg. 8725, 8726 (Feb. 15, 2012) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pt. 147).

[16] *See id*.

[17] 77 Fed. Reg. at 8728.

[18] 77 Fed. Reg. at 8727.

harbor, the Departments plan to develop and propose changes to the final regulations that would accommodate these nonprofit organizations:

> Specifically, the Departments plan to initiate a rulemaking to require issuers to offer insurance without contraception coverage to such an employer (or plan sponsor) and simultaneously to offer contraceptive coverage directly to the employer's plan participants (and their beneficiaries) who desire it. Under this approach, the Departments will also require that, in this circumstance, there be no charge for the contraceptive coverage.[19]

In guidance issued by HHS, the agency explained that the temporary enforcement safe harbor will be in effect until the first plan year that begins on or after August 1, 2013.[20] The guidance indicates that organizations that meet all of the following criteria will not be subject to enforcement action for failing to provide contraceptive coverage in a group health plan that it establishes or maintains:

> (1) The organization is organized and operates as a non-profit entity.
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> (2) From February 10, 2012 onward, contraceptive coverage has not been provided at any point by the group health plan established or maintained by the organization, consistent with any applicable State law, because of the religious beliefs of the organization.
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> (3) The group health plan established or maintained by the organization provides to participants notice, as prescribed in the guidance, that states that contraceptive coverage will not be provided under the plan for the first plan year beginning on or after August 1, 2012.
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> (4) The organization self-certifies that it satisfies the aforementioned criteria and documents its self-certification in accordance with procedures prescribed in the guidance.[21]

Finally, the guidance maintains that the DOL and the Treasury will also not take any enforcement action against an organization that complies with the conditions of the temporary enforcement safe harbor.[22]

The requirement to provide preventive health services, along with many other insurance market reforms in ACA, applies to group health plans, broadly defined as plans established or maintained by an employer and that provide medical care.[23] In general, group health plans can be insured (i.e., purchased from an insurance carrier) or self-insured (funded directly by an employer).[24] These requirements of ACA also apply to "health insurance issuers," health insurers that issue a policy or contract to provide group or individual health insurance coverage.[25] However, several of ACA's insurance market reforms, including

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[19] 77 Fed. Reg. at 8728.

[20] Center for Consumer Info. and Ins. Oversight, Centers for Medicare & Medicaid Services, U.S. Dept. of Health and Human Services, Guidance on the Temporary Enforcement Safe Harbor for Certain Employers, Group Health Plans and Group Health Insurance Issuers with Respect to the Requirement to Cover Contraceptive Services Without Cost Sharing Under Section 2713 of the Public Health Service Act, Section 715(a)(1) of the Employee Retirement Income Security Act, and Section 9815(a)(1) of the Internal Revenue Code (Feb. 10, 2012), http://cciio.cms.gov/resources/files/Files2/02102012/20120210-Preventive-Services-Bulletin.pdf.

[21] *Id*. at 3.

[22] *Id*. at 2.

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

[24] 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.

[25] A health insurance issuer is defined as an insurance company, insurance service, or insurance organization that is licensed to (continued...)

the preventive health services requirements, do not apply to "grandfathered health plans," which are existing group health plans or health insurance coverage (including coverage from the individual health insurance market) in which a person was enrolled on the date of enactment of ACA (i.e., March 23, 2010).[26] As discussed above, with respect to the preventive health services requirements in ACA, health plans and health insurance coverage established or maintained by a "religious employer" could be exempt from providing contraceptive services, and certain organizations with religious objections to contraceptive coverage will not be subject to an enforcement action under a temporary enforcement safe harbor. Aside from these exceptions, however, if a group health plan or health insurance issuer is subject to the insurance market reforms in Title I of ACA, it seems that the penalties discussed below could be potentially applied if health coverage was not provided in line with federal requirements.[27]

Enforcement of ACA's Insurance Reforms Under ERISA, the PHSA and the IRC

Neither the preventive health services requirement itself nor several of the other insurance reforms in Title I of ACA expressly include a means for enforcing these new health insurance standards,[28] although these new standards were added to Title XXVII of the Public Health Service Act (PHSA) and incorporated into Part 7 of the Employee Retirement Income Security Act (ERISA) and Chapter 100 of the Internal Revenue Code (IRC).[29] Thus, if these new health insurance standards are not followed, it appears that enforcement may be carried out through mechanisms (such as judicial review and other penalties) that existed prior to ACA in these three federal statutes.

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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).

[26] For a general discussion of grandfathered health plans, *see* CRS Report R41166, *Grandfathered Health Plans Under the Patient Protection and Affordable Care Act (ACA)*, by Bernadette Fernandez.

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

[28] However, one exception is section 2715(f) of the PHSA, created by section 1001 of ACA, which provides that if health insurance issuers and certain group health plans willfully fail to provide a summary of benefits and coverage as required by the section, they will be subject to a fine of not more than $1,000 for each failure. *See* 42 U.S.C. §300gg-15(f)(2). Another exception is section 2718 of the PHSA, created by section 1001 of ACA, relating to minimum loss ratio requirements. This section provides that the Secretary of HHS "shall promulgate regulations for enforcing the provisions of this section and may provide for appropriate penalties." 42 U.S.C. §300gg-18.

[29] Section 1563 of ACA provides that the new PHSA requirements apply to group health plans, and health insurance issuers providing health insurance coverage under ERISA and the IRC as if they were included in the statutes; and to the extent that a provision of those statutes conflicts with a provision added by ACA, the provisions of ACA apply. P.L. 111-148, §1563(e)-(f). It should be noted that, perhaps because of a technical error, there is more than one Section 1563 contained in ACA. The Section 1563 relevant to this discussion is entitled "Conforming Amendments."

In general, health plans can be subject to ERISA, the PHSA, and the IRC, but enforcement may be carried out differently, depending on the particular plan at issue. While the enforcement mechanisms are different under each of the three statutes, the Secretaries of HHS, Labor, and the Treasury have shared interpretive and enforcement authority.[30]

ERISA

Private-sector employee benefit plans are largely regulated at the federal level under ERISA. In general, Part 7 of ERISA is administered by the Department of Labor and regulates health coverage provided by private-sector employers. ERISA applies to insured and self-insured group health plans offered by these employers, as well as insurance issuers providing this group health coverage. However, ERISA does not generally apply to governmental[31] or church plans.[32] The provisions of ACA were incorporated by reference into Part 7 of ERISA. The Secretary of Labor may take enforcement action against group health plans of employers that violate ERISA, but may not enforce ERISA's requirements against health insurance issuers.[33] In addition, section 502(a) of ERISA authorizes various civil actions that may be brought by a participant or beneficiary of a plan against group health plans and health insurance issuers. This section also provides for and limits the remedies (i.e., relief) available to a successful plaintiff.

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.[34] Under this section, if a plaintiff's claim for benefits is improperly denied, the plaintiff may sue to recover the unpaid benefit. Since ACA did not amend section 502 of ERISA, presumably the section would authorize review of claims arising out of a violation of the incorporated ACA provisions. Accordingly, if a group health plan or health insurance issuer failed to provide contraceptive services pursuant to guidelines authorized by ACA, it seems possible, for example, that a plan participant could be able to bring a claim for that benefit.

The PHSA

Similar to ERISA, Title XXVII of the Public Health Service Act, administered by HHS, also applies to employment-based group health plans and health insurance coverage provided in connection with these plans. However, the PHSA also applies to governmental plans and insurance coverage in the individual

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[30] *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.

[31] 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).

[32] Section 3 of ERISA provides that a "church plan" means "a plan established and maintained … for its employees (or their beneficiaries) by a church or by a convention or association of churches which is exempt from tax under section 501 of the Internal Revenue Code…". 29 U.S.C. §1002(33)(A). This section also states that "[a] plan established and maintained for its employees (or their beneficiaries) by a church or by a convention or association of churches includes a plan maintained by an organization, whether a civil law corporation or otherwise, the principal purpose or function of which is the administration or funding of a plan or program for the provision of retirement benefits or welfare benefits, or both, for the employees of a church or a convention or association of churches, if such organization is controlled by or associated with a church or a convention or association of churches." …". 29 U.S.C. §1002(33)(C). It should be noted that this memorandum does not address distinctions between church plans and plans established or maintained by "religious employers" pursuant to the final rules implementing the preventive health services requirements.

[33] 29 U.S.C. §1132(b)(3).

[34] 29 U.S.C. §1132(a)(1)(B).

market. In general, the private health insurance requirements of Title XXVII of the PHSA, as amended by ACA, may be enforced against health insurance issuers and non-federal self-funded governmental group plans.[35] Prior to ACA, state and local governments could elect to exempt their plans from certain requirements of the PHSA, subject to certain exceptions.[36] However, this election is not applicable to the provisions added to the PHSA by ACA, and thus these plans are subject to ACA's federal health insurance standards.[37]

Enforcement of the PHSA requirements is different for health insurance issuers than for governmental plans. The Secretary of HHS is the primary enforcer of the PHSA requirements with respect to non-federal governmental plans. But, with respect to health insurance issuers, states are the primary enforcers of the private health insurance requirements.[38] The PHSA provides that "[i]n the case of a determination by the Secretary [of HHS] that a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) … insofar as they relate to the issuance, sale, renewal, and offering of health insurance coverage in connection with group health plans or individual health insurance coverage in such State."[39] It appears that failure to provide contraceptive services may be seen as a failure to comply with the requirements of the PHSA and may trigger these enforcement mechanisms.

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.[40] 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.

IRC

The IRC, as administered by the Department of the Treasury, covers employment-based group health plans, including church plans, but does not apply to health insurance issuers.[41] Under the IRC, failure to meet the group health plan requirements is enforced through the imposition of an excise tax.[42] For single-employer plans, employers are generally responsible for paying this excise tax. Under multiemployer plans, the tax is imposed on the plan.[43] A group health plan that fails to comply with the pertinent

[35] 42 U.S.C. §300gg-21(a)(1).

[36] 42 U.S.C. §300gg-21(a)(2)(A).

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

[38] 42 U.S.C. §300gg-22(a)(1).

[39] 42 U.S.C. §300gg-22(a)(2).

[40] 42 U.S.C. §300gg-22(b)(2)(C)(i).

[41] However, it should be noted that section 9815 of the IRC, the provision that incorporates the private health insurance reforms into the Internal Revenue Code, states that "the provisions of part A of title XXVII of the Public Health Service Act (as amended by the Patient Protection and Affordable Care Act) shall apply to group health plans, *and health insurance issuers* providing health insurance coverage in connection with group health plans, as if included in this subchapter…." It is unclear how this language affects the application of the IRC to health insurance issuers, and this memorandum will not address this issue.

[42] 26 U.S.C. §4980D.

[43] 26 U.S.C. §4980D(e).

requirements in the IRC may be subject to a tax of $100 for each day in the noncompliance period[44] 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. Limitations on a tax may be applicable under certain circumstances (e.g., if the failure was due to reasonable cause and not to willful neglect, and is corrected within a specified time frame). It should be noted that church plans are exempt from minimum excise tax requirements, and may have a longer time frame to correct a violation before a tax is imposed.[45]

[44] 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).

[45] 26 U.S.C. §4980D(b)-(c).