FAQs on HIPAA Portability and Nondiscrimination Requirements for Employers and Advisers

U. S. Department of Labor
Employee Benefits Security Administration

Q1: What is HIPAA?

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) includes provisions of Federal law governing health coverage portability, health information privacy, administrative simplification, medical savings accounts, and long-term care insurance. The responsibility of the Department of Labor and the subject of these FAQs are the law's portability and nondiscrimination requirements.

HIPAA's provisions affect group health plan coverage in the following ways:

- Provide certain individuals special enrollment rights in group health coverage when specific events occur, e.g., birth of a child (regardless of any open season);
- Prohibit discrimination in group health plan eligibility, benefits, and premiums based on specific health factors; and
- While HIPAA previously provided for limits with respect to preexisting condition exclusions, new protections under the Affordable Care Act now prohibit preexisting condition exclusions for plan years beginning on or after January 1, 2014. For plan years beginning on or after January 1, 2014, plans are no longer required to issue the general notice of preexisting condition exclusion and individual notice of period of preexisting condition exclusion. Plans are also no longer required to issue certificates of creditable coverage after December 31, 2014. These amendments were made because plans are prohibited from imposing preexisting condition exclusions for plan years beginning on or after January 1, 2014.

Special Enrollment

Q2: What is special enrollment?

Group health plans are required to provide special enrollment periods during which individuals who previously declined health coverage for themselves and their dependents may be allowed to enroll (regardless of any open enrollment period). In addition to HIPAA special enrollment rights, the Children's Health Insurance Program Reauthorization Act (CHIPRA) added additional special enrollment rights under ERISA. Rights related to CHIPRA special enrollment are discussed in this section.

Special enrollment rights can occur when:

- An individual loses eligibility for coverage under a group health plan or other health insurance coverage (such as an employee and his/her dependents' loss of coverage under the spouse's plan) or when an employer terminates contributions toward health coverage;

- An individual becomes a new dependent through marriage, birth, adoption, or being placed for adoption; and
- An individual loses coverage under a State Children's Health Insurance Program (CHIP) or Medicaid, or becomes eligible to receive premium assistance under those programs for group health plan coverage.

Employees must receive a description of special enrollment rights on or before the date they are first offered the opportunity to enroll in the group health plan (*see* model notice).

In addition, employers that maintain a group health plan in a state with a CHIP or Medicaid program that provides for premium assistance for group health plan coverage must provide a notice (referred to as the Employer CHIP Notice) to all employees to inform them of possible opportunities in the state in which they reside (for more information on a model Employer CHIP Notice, *see* Q4).

Some individuals losing coverage under an employment-based group health plan may want to consider enrolling for coverage in the Marketplace. For more information on the Marketplace, visit **HealthCare.gov**.

Q3: Can the special enrollment notice be provided in the Summary Plan Description (SPD)?

Yes, if the SPD is provided to the employee at or before the time the employee is initially offered the opportunity to enroll in the plan. If the SPD is provided at a later time, the special enrollment notice should be provided separately (for example, as part of the application for coverage).

Q4: How can the employer notice regarding premium assistance under Medicaid or CHIP (the Employer CHIP Notice) be provided?

Employers that maintain a group health plan are required to provide the Employer CHIP Notice if they provide medical care in a State that operates a Medicaid or CHIP premium assistance program. This notice may be provided with the SPD, enrollment packets or open season materials as long as these materials are provided no later than the date explained below, are provided to all employees, and are provided in accordance with the Department of Labor's disclosure rules. The notice must be provided annually.

A model Employer CHIP Notice is available. The model notice includes State contact information for States that provide Medicaid or CHIP premium assistance programs. This contact information will be updated periodically, therefore, be sure to check the EBSA Website for the most recent version.

Q5: Upon loss of eligibility for health coverage or termination of employer contributions for health coverage, what are a plan's obligations to offer special enrollment?

When an employee or dependent loses eligibility for coverage under any group health plan or health insurance coverage, or if employer contributions toward group health plan coverage cease, a special enrollment opportunity may be triggered. The employee or dependent must have had health coverage when the group health plan benefit package was previously declined. If the other coverage was COBRA continuation coverage, special enrollment need not be made available until the COBRA coverage is exhausted.

For example, if an employee's spouse declined coverage when previously offered due to coverage under her own employer's plan, she and the employee must be offered a special enrollment

opportunity when her coverage ceases under that plan or her employer terminates contributions to that plan.

Another example is if an employer offering two benefit package options, an HMO and an indemnity option, eliminates coverage under the indemnity option. Employees, spouses, and other dependents must be offered a special enrollment opportunity in the HMO option (and may also be eligible to special enroll in any other plan for which they are otherwise eligible, such as any plan offered by the spouse's employer).

Q6: What are examples of a loss of eligibility for coverage?

Some examples of events that cause an individual to lose eligibility for health coverage (there are other reasons as well):

- Divorce or legal separation;
- A dependent is no longer considered a dependent under the plan;
- Death of the employee covered by the plan;
- Termination of employment;
- Reduction in the number of hours of employment;
- The plan decides to no longer offer any benefits to a class of similarly situated individuals; or
- An individual in an HMO or other arrangement no longer resides, lives, or works in the service area.

Q7: If an employer terminates all contributions to a group health plan, but individuals have the option to continue coverage and pay 100 percent of the cost themselves, would these individuals still have a special enrollment right because the employer has terminated contributions?

Yes. If all employer contributions have ended, individuals covered under the plan would have a special enrollment right, regardless of their option to continue coverage under the plan by paying the full cost of coverage.

Q8: If a plan has to offer a special enrollment period upon loss of eligibility or termination of employer contributions, how long must the special enrollment period run?

The plan has to provide at least 30 days for the employee or dependent to request coverage after the loss of other coverage or termination of employer contributions.

If an individual does request coverage within the 30-day period, the plan must make the coverage effective no later than the first day of the first calendar month beginning after the date the plan receives the enrollment request.

Q9: Upon marriage, birth, adoption, or placement for adoption, what are a plan's obligations to offer special enrollment?

Employees, as well as their spouses and dependents, may have special enrollment rights after a marriage, birth, adoption, or placement for adoption. In addition, new spouses and new dependents of retirees in a group health plan also may have special enrollment rights after these events.

The plan has to provide at least 30 days for the employee or dependents to request coverage after the occurrence of one of these events.

If the event was a marriage, the coverage is required to be effective no later than the first day of the first calendar month beginning after the date the completed request for enrollment is received by the plan.

In the case of birth, adoption, or placement for adoption, coverage is required to be effective no later than the date of the event.

Q10: If an employee or dependent loses coverage under CHIP or Medicaid, or becomes eligible for State premium assistance under those programs, what are a plan's obligations to offer special enrollment?

A special enrollment opportunity is triggered if the employee or dependent who is otherwise eligible, but not enrolled in, a group health plan:

- loses eligibility for coverage under a State Medicaid or CHIP program, or
- becomes eligible for State premium assistance under a Medicaid or CHIP program.

The plan must provide at least 60 days for the employee or dependent to request coverage after the employee or dependent loses eligibility for coverage or becomes eligible for premium assistance.

Q11: Can States modify HIPAA's special enrollment requirement?

Yes, in certain circumstances. States may require additional special enrollment periods with respect to insured group health plans.

State laws related to health insurance issuers generally continue to apply except to the extent that such State law "prevents the application of" a requirement of Part 7 of ERISA. Therefore, if health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State's insurance laws.

Nondiscrimination Requirements

Q12: What is nondiscrimination?

Under HIPAA, individuals may not be denied eligibility or continued eligibility to enroll in a group health plan based on any health factors they may have. In addition, an individual may not be charged more for coverage than any similarly situated individual is being charged based on any health factor.

Note: Compliance with HIPAA's nondiscrimination provisions does not in any way reflect compliance with any other provision of ERISA (including COBRA and ERISA's other fiduciary provisions). Nor does it reflect compliance with other State or Federal laws (such as the Americans with Disabilities Act).

Q13: What are the "health factors"?

They are:

- health status;
- medical condition, including both physical and mental illnesses;

- claims experience;
- receipt of health care;
- medical history;
- genetic information;
- evidence of insurability; and
- disability.

The term "evidence of insurability" includes conditions arising from acts of domestic violence, as well as participation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities.

Q14: Can a group health plan require an individual to pass a physical examination in order to be eligible to enroll in the plan?

No. A group health plan may not require an individual to pass a physical exam for enrollment, even if the individual is a late enrollee.

Q15: Can a plan require an individual to complete a health care questionnaire in order to enroll?

Yes, provided that the questionnaire does not ask for genetic information (including family medical history) and the health information is not used to deny, restrict, or delay eligibility or benefits, or to determine individual premiums.

Q16: Can plans exclude or limit benefits for certain conditions or treatments?

Group health plans may exclude coverage for a specific disease, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination that the benefits are experimental or medically unnecessary – but only if the benefit restriction applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on a health factor they may have. (Plan amendments that apply to all individuals in a group of similarly situated individuals and that are effective no earlier than the first day of the next plan year after the amendment is adopted are not considered to be directed at individual participants and beneficiaries.) Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under other laws including the Affordable Care Act. For example, the Affordable Care Act includes requirements related to coverage of certain preventive services.

Q17: Can a plan deny benefits otherwise provided for the treatment of an injury based on the source of that injury?

If the injury results from a medical condition or an act of domestic violence, a plan may not deny benefits for the injury – if it is an injury the plan would otherwise cover.

For example, a plan may not exclude coverage for self-inflicted injuries (or injuries resulted from attempted suicide) if the individual's injuries are otherwise covered by the plan and if the injuries are the result of a medical condition (such as depression).

However, a plan may exclude coverage for injuries that do not result from a medical condition or domestic violence, such as injuries sustained in high-risk activities (for example, bungee jumping). But

the plan could not exclude an individual from enrollment for coverage because the individual participated in bungee jumping.

Q18: Can a plan charge individuals with histories of high claims more than similarly situated individuals based on their claims experience?

No. Group health plans cannot charge an individual more for coverage than other similarly situated individuals based on any health factor.

Q19: How are groups of similarly situated individuals determined?

Distinctions among groups of similarly situated participants in a health plan must be based on bona-fide employment-based classifications consistent with the employer's usual business practice. Distinctions cannot be based on any of the health factors noted earlier.

For example, part-time and full-time employees, employees working in different geographic locations, and employees with different dates of hire or lengths of service can be treated as distinct groups of similarly situated individuals, with different eligibility provisions, different benefit restrictions, or different costs, provided the distinction is consistent with the employer's usual business practice.

In addition, a plan generally may treat participants and beneficiaries as two separate groups of similarly situated individuals. The plan also may distinguish between beneficiaries based on, for example, their relationship to the plan participant (such as spouse or dependent child) or based on the age or student status of dependent children.

In any case, a plan cannot create or modify a classification directed at individual participants or beneficiaries based on one or more of the health factors.

Q20: Is it permissible for a health insurance issuer to charge a higher premium to one group health plan (or employer) that covers individuals, some of whom have adverse health factors, than it charges another group health plan comprised of fewer individuals with adverse health factors?

Yes. In fact, HIPAA does not restrict a health insurance issuer from charging a higher rate to one group health plan (or employer) over another. An issuer may take health factors of individuals into account when establishing blended, aggregate rates for group health plans (or employers). This may result in one health plan (or employer) being charged a higher premium than another for the same coverage through the same issuer. Whether any plan provision or practice with respect to benefits complies with this rule under HIPAA does not affect whether the provision or practice is permitted under the Affordable Care Act (including the requirements related to community rating administered by HHS).

Q21: Can a health insurance issuer charge an employer different premiums for each individual within a group of similarly situated individuals based on each individual's health status?

No. Issuers may not charge or quote an employer or group health plan separate rates that vary for individuals (commonly referred to as "list billing") based on any of the health factors.

HIPAA does not prevent issuers from taking the current health status of each individual into account when establishing a blended, aggregate rate for providing coverage to the employment-based group overall. (However, the Affordable Care Act generally prohibits this practice with respect to small group insurance plans.) (Note: group health plans cannot adjust premium or contribution rates based on

genetic information of one or more individuals in the group. For more information, refer to the GINA FAQs.) Also, under the Affordable Care Act, the issuer may then charge the employer (or plan) a higher overall rate, or a higher blended per-participant rate.

While HIPAA prohibits list billing based on health factors, it does not restrict communications between issuers and employers (or plans) regarding the factors considered in the rate calculations.

Q22: Can a group health plan impose a nonconfinement clause (e.g., a clause stating that if an individual is confined to a hospital at the time coverage would otherwise take effect, coverage would not begin until that individual is no longer confined)?

No. A group health plan may not deny or delay an individual's eligibility, benefits, or the effective date of coverage because that individual is confined to a hospital or other health care facility. In addition, a health plan may not set an individual's premium rate based on that individual's confinement.

Q23: Can a group health plan impose an "actively-at-work" provision (e.g., a requirement that an employee be actively at work after a waiting period for enrollment in order to have health coverage become effective on that day)?

No. Generally a group health plan may not refuse to provide benefits because an individual is not actively at work on the day that individual would otherwise become eligible for benefits. However, plans may have actively-at-work clauses if the plan treats individuals who are absent from work due to a health factor (for example, individuals taking sick leave) as if they are actively at work for purposes of health coverage.

Plans may require individuals to report for the first day of work before coverage may become effective. In addition, plans may distinguish among groups of similarly situated individuals in their eligibility provisions. For example, a plan may require an individual to work full time, such as 250 hours per quarter or 30 hours per week, to be eligible for health plan coverage.

Q24: Is it permissible for a group health plan that generally provides coverage for dependents only until age 26 to continue health coverage past that age for disabled dependents?

Yes, a plan can treat an individual with an adverse health factor more favorably by offering extended coverage.

HIPAA and the Affordable Care Act Wellness Program Requirements

Q25: Are there regulations related to wellness programs?

The U.S. Departments of Labor, Health and Human Services and the Treasury issued final regulations on incentives for nondiscriminatory wellness programs in group health plans under the Affordable Care Act and the HIPAA nondiscrimination provisions. These rules apply to both grandfathered and nongrandfathered group health plans.

Q26: Are wellness programs provided in connection with a group health plan allowed under the Affordable Care Act and HIPAA?

The Affordable Care Act and HIPAA generally prohibit group health plans from charging similarly situated individuals different premiums or contributions or imposing different deductibles, copayment or other cost sharing requirements based on a health factor. However, there is an exception that allows plans to offer wellness programs.

There are two types of wellness programs provided in connection with a group health plan. Participatory wellness programs are generally available without regard to an individual's health status. Either no reward is offered, or none of the conditions for obtaining a reward are based on an individual satisfying a standard related to a health factor. These programs comply with the nondiscrimination requirements so long as the program is made available to all similarly situated individuals. For example:

- A program that reimburses all or part of the cost for memberships in a fitness center.
- A diagnostic testing program that provides a reward for participation and does not base any part of the reward on outcomes.
- A program that reimburses employees for the costs of participating, or that otherwise provides a reward for participating, in a smoking cessation program without regard to whether the employee quits smoking.
- A program that provides a reward to employees for attending a monthly, no-cost health education seminar.

Health-contingent wellness programs require participants to satisfy a standard related to a health factor in order to obtain a reward. There are two types of health contingent wellness programs: activity-only and outcome-based. Activity-only programs require an individual to perform or complete an activity related to a health factor in order to obtain a reward. Examples include a walking, diet or exercise program. Outcome-based programs require an individual to attain or maintain a specific health outcome (such as not smoking or attaining certain results on biometric screenings) in order to obtain a reward. To comply with the nondiscrimination rules, health-contingent wellness programs must meet five requirements described in the final rules.

Q27: What are the five requirements for health-contingent wellness programs under the final regulations?

1. The program must give individuals eligible to participate the opportunity to qualify for the reward at least once per year.
2. The total reward for all the plan's wellness programs that require satisfaction of a standard related to a health factor is limited – generally, it must not exceed 30 percent (or 50 percent for programs designed to prevent or reduce tobacco use) of the cost of employee-only coverage under the plan. If dependents (such as spouses and/or dependent children) may participate in the wellness program, the reward must not exceed 30 percent (or 50 percent) of the cost of the coverage in which an employee and any dependents are enrolled.
3. The program must be reasonably designed to promote health and prevent disease. (Note: different requirements apply for activity-only and outcome-based programs, as described later in this section.)
4. The full reward must be available to all similarly situated individuals. This means the program must allow a reasonable alternative standard (or waiver of the otherwise applicable standard). (Note: different requirements apply for activity-only and outcome-based programs, as described later in this section.)
5. The plan must disclose in all materials describing the terms of the program the availability of a reasonable alternative standard (or the possibility of a waiver of the otherwise applicable standard). (Note: different requirements apply for activity-only and outcome-based programs, as described later in this section.) Model language is available.

Q28: What factors may be considered in determining whether a program is reasonably designed to promote health and prevent disease?

An activity-only or outcome-based program is considered reasonably designed to promote health or prevent disease, if the program has a reasonable chance of improving the health of, or preventing disease in, participating individuals; is not overly burdensome; is not a subterfuge for discrimination based on a health factor; and is not highly suspect in the method chosen to promote health or prevent disease. The determination is based on all the relevant facts and circumstances.

To ensure that an outcome-based wellness program is reasonably designed to improve health and does not act as a subterfuge for underwriting or reducing benefits based on a health factor, a reasonable alternative standard to qualify for the reward must be provided to any individual who does not meet the initial standard based on a test or screening that is related to a health factor.

Q29: Under what circumstances must a reasonable alternative standard be offered?

For activity-only programs, a reasonable alternative standard (or waiver of the otherwise applicable standard) must be offered to any individual for whom it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard, or for whom it is medically inadvisable to attempt to satisfy the otherwise applicable standard. Plans can seek physician verification with respect to a request for a reasonable alternative standard, if the request is reasonable under the circumstances.

For outcome-based programs, the reasonable alternative standard (or waiver of the otherwise applicable standard) must be offered to any individual who does not meet the initial standard based on the measurement, test or screening. If the reasonable alternative standard is, itself, another outcome-based wellness standard, the reasonable alternative cannot be a requirement to meet a different level of the same standard without additional time to comply that takes into account the individual's circumstances and an individual must be given the opportunity to comply with the recommendations of their personal physician as a second reasonable alternative standard (if the physician joins in the request). It is not reasonable for plans to seek physician verification that a health factor makes it unreasonably difficult for the individual to satisfy, or medically inadvisable for the individual to attempt to satisfy a standard under an outcome-based wellness program.

For all health-contingent wellness programs (whether activity-only or outcome-based), all of the facts and circumstances are taken into account when determining whether a plan has provided a reasonable alternative standard, including but not limited to the following:

- If the reasonable alternative standard is completion of an educational program, the plan or issuer must make the educational program available or assist the employee in finding such a program (instead of requiring an individual to find such a program unassisted), and may not require an individual to pay for the cost of the program.
- The time commitment required must be reasonable (for example, requiring attendance nightly at a one hour class would be unreasonable).
- If the reasonable alternative standard is a diet program, the plan or issuer is not required to pay for the cost of food but must pay any membership or participation fee.
- If an individual's personal physician states that a program standard (including, if applicable, the recommendations of the plan's medical professional) is not medically appropriate for that individual, the plan or issuer must provide a reasonable alternative standard that accommodates the recommendations of the individual's personal physician with regard to medical appropriateness. Plans and issuers may impose standard cost sharing under the plan or coverage for medical items and services furnished pursuant to the physician's recommendations.

Q30: What disclosure is required for the availability of a reasonable alternative standard?

Plans and issuers must disclose the availability of a reasonable alternative standard to qualify for the reward (and, if applicable, the possibility of waiver of the otherwise applicable standard) in all plan materials describing the terms of a health-contingent wellness program (both activity-only and outcome-based wellness programs). This disclosure must include contact information for obtaining the alternative and a statement that recommendations of an individual's personal physician will be accommodated. If plan materials merely mention that such a program is available, without describing its terms, this disclosure is not required.

In addition, for outcome-based wellness programs, this notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard, for example a notice than an individual did not meet the BMI target range to qualify for the reward.

Q31: How do the wellness program rules apply to a group health plan that offers a reward to individuals who participate in voluntary testing for early detection of health problems? The plan does not use the test results to determine whether an individual receives a reward or the amount of an individual's reward.

Such a program is considered a participatory wellness program since it does not base any reward on the outcome of the testing. Thus, it is allowed under the HIPAA nondiscrimination provisions as long as the program is made available to all similarly situated individuals, without being subject to the five requirements that apply to health-contingent wellness programs.

Q32: Can a plan provide a premium differential between smokers and nonsmokers?

The plan is offering a reward based on an individual's ability to stop smoking. This is considered an outcome-based wellness program. For the plan to implement this type of program, the plan's nonsmoking program would need to meet the five requirements for wellness programs that require satisfaction of a standard related to a health factor.

Accordingly, this wellness program is permitted if:

- The premium differential is not more than 50 percent of the total cost of employee-only coverage (or 50 percent of the cost of coverage if dependents can participate in the program);
- The program is reasonably designed to promote health and prevent disease;
- Individuals eligible for the program are given an opportunity to qualify for the discount at least once per year;
- The program provides a reasonable alternative standard, without physician verification that the individual met the standard, to all individuals who do not meet the otherwise applicable standard (those who use tobacco products). For example, the reasonable alternative standard could include discounts in return for attending educational classes or for trying a nicotine patch; and
- Plan materials describing the terms of the premium differential (and any disclosure that an individual did not satisfy the wellness program standard) describe the availability of a reasonable alternative standard to qualify for the lower premium.

Applying and Enforcing Laws in Part 7 of ERISA

Q33: Are certain benefits exempt from the requirements in Part 7 of ERISA, including HIPAA and the Affordable Care Act?

Part 7 of ERISA (Part 7) does not apply to plans with respect to their provision of "excepted benefits."

Some benefits, such as accidental death and dismemberment benefits, are always excepted benefits and are not subject to the laws in Part 7, including HIPAA and the Affordable Care Act. Other benefits, including 1) limited-scope dental and limited-scope vision benefits, 2) benefits under certain health flexible spending arrangements, 3) noncoordinated benefits, and 4) supplemental benefits may be excepted if certain criteria are met.

More specific information on dental-only and vision-only coverage and supplemental excepted benefits is provided in this section. For more information on other types of excepted benefits, *see* 29 CFR 2590.732(c) or contact the EBSA office nearest you.

Q34: Are dental-only and vision-only coverage subject to Part 7?

It depends. These benefits may constitute limited-scope excepted benefits (and, therefore, are not subject to Part 7) if:

- The benefits are offered under a separate insurance policy, certificate, or contract of insurance. (This is an option for insured plans only.)
  or
- The benefits are "not an integral part of the plan." (This is an option for both insured and self-insured plans.) Under the final rules issued in September 2014, benefits are not an integral part of the plan if participants have the right to elect not to receive coverage for the benefits.

Q35: Is supplemental health insurance coverage subject to Part 7?

It depends. Three types of coverage may qualify as supplemental excepted benefits (and, therefore, are not subject to Part 7): Medicare supplemental health insurance, TRICARE supplemental programs, and similar supplemental coverage provided to coverage under a group health plan.

Coverage will be treated as "similar supplemental coverage" if it is provided under a separate policy, certificate, or contract of insurance, and it satisfies these requirements:

- The supplemental coverage must be issued by an entity that does not provide the plan's primary coverage;
- It must be specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles (but does not include coverage that becomes secondary or supplemental only under a coordination-of-benefits provision);
- The cost of supplemental coverage must not exceed 15 percent of the cost of primary coverage; and
- The supplemental coverage must not differentiate among individuals and dependents in eligibility, benefits, or premiums based on any health factor.

See Field Assistance Bulletin 2007-04 for more information.

Q36: Who enforces the requirements of Part 7 of ERISA and parallel requirements under the Internal Revenue Code and the Public Health Service Act?

The Secretary of Labor enforces the requirements under ERISA for private-sector group health plans. In addition, participants and beneficiaries can sue both plans and issuers to enforce their rights under ERISA.

The Secretary of the Treasury enforces requirements for private-sector group health plans under the Code. A taxpayer that fails to comply may be subject to certain excise taxes or penalties.

States also have enforcement responsibility, including sanctions available under State law, for requirements imposed on health insurance issuers. If a State does not act in the areas of its responsibility or does not have authority to enforce, the Secretary of Health and Human Services may assert Federal authority to enforce, and impose sanctions on insurers as specified in the statute, including civil monetary penalties.

Q37: Can State laws apply to employment-based group health plan coverage?

State laws related to health insurance issuers generally continue to apply except to the extent that such State law "prevents the application of" a requirement of Part 7 of ERISA. Therefore, if health coverage is offered through an HMO or an insurance policy, check with your State insurance department for more information on that State's insurance laws.