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Health Insurer Market Behavior After the Affordable Care Act: Assessing the Need for Monitoring, Targeted Enforcement, and Regulatory Reform

John V. Jacobi,* Tara Adams Ragone,** and Kate Greenwood***

ABSTRACT

The primary goal of the Patient Protection and Affordable Care Act ("ACA") is to connect Americans with affordable, medically necessary health care. The first step toward achieving that goal is insurance expansion. The ACA's first two years of insurance expansion have allowed millions of Americans to join the ranks of the insured. The second step recognizes that the content of health coverage matters, as appropriate insurance connects consumers with necessary care. The ACA therefore requires most plans offered in the individual and small-

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group markets to cover a slate of ten essential health benefits. There is a third necessary step in fulfilling the promise of the ACA, however. Once people are connected with insurance plans covering essential health benefits, it is vitally important that the plans deliver on the promise to provide necessary care in a timely, appropriate manner. The expanded health insurance markets, however, are built on the state-regulated, market-driven health insurance system that predated the passage of the ACA. Whether consumers fare well or poorly after the ACA will depend on the market behavior of the health insurers selling individual and small-group plans.

This Article focuses on four aspects of the market behavior of private health insurance plans that have historically caused concern: (1) contractual exclusions of certain categories of care from coverage, (2) utilization review and "medical necessity" judgments, (3) restricted provider networks, and (4) discrimination in plan design and administration. With regard to all four aspects, this Article contends that there continues to be a need for monitoring by advocates, federal and state regulators, and others, as well as for targeted enforcement, to ensure that the promise of the ACA is fulfilled. Information derived from monitoring and enforcement should in turn create a feedback loop enabling federal and state policymakers to determine where regulatory reform is needed.

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I. INTRODUCTION

The primary goal of the Patient Protection and Affordable Care Act ("ACA") is to connect Americans with affordable, medically necessary health care.[1] The first step toward achieving that goal is insurance expansion. The ACA's initial open enrollment period for private insurance ended in the spring of 2014 with approximately eight million enrolled through state or federal health insurance exchanges, and another five million enrolled in ACA-compliant plans sold outside the exchanges.[2] The second step recognizes that the content of health coverage matters, as appropriate insurance connects consumers with necessary care. The ACA therefore requires most plans offered in the individual and small group markets to cover a slate of ten essential health benefits ("EHBs").[3]

The ACA has been successful in expanding coverage, including coverage in the small group and individual markets in which EHB requirements apply.[4] EHB requirements, in turn, are intended to supplement the coverage requirements in state law to ensure that the beneficiaries of most individual and small group plans receive coverage

1. Patient Protection and Affordable Care Act (PPACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (codified primarily in various sections of Titles 5, 18, 20, 21, 25, 26, 31, and 42 of the United States Code). PPACA is often referred to as the "Affordable Care Act," or the "ACA," and will be referred to as such herein. The ACA "fulfilled [President Obama's] goal of extending health-insurance coverage to virtually all Americans." Michael J. Graetza & Jerry L. Mashaw, *Constitutional Uncertainty and the Design of Social Insurance: Reflections on the Obamacare Case*, 7 HARV. L. & POL'Y REV. 343, 343 (2013).

2. U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL OPEN ENROLLMENT PERIOD 7 (May 2014).

3. *See* 42 U.S.C. § 300gg-6(a) (2012) (requiring insurers in the individual and small group markets to cover EHBs); 42 U.S.C.§ 18022(b)(1) (defining the "general categories and the items and services" included in EHBs).

4. *See Survey: Nearly 9 in 10 US Adults Now Have Health Insurance,* N.Y. TIMES, Apr. 13, 2015, http://www.nytimes.com/aponline/2015/04/13/us/politics/ap-us-health-overhaul-uninsured.html.

that is comprehensive and responsive to most peoples' health care needs.[5] These two steps–making insurance available, and requiring that most individual and small group plans promise to cover health services mandated by state and federal law–are not, however, enough to assure that consumers in the individual and small group markets will have appropriate access to medically necessary services. The third step is ensuring that the plans deliver on the promise to provide necessary care in a timely, appropriate manner.[6]

The expanded health insurance markets are built on the state-regulated, market-driven health insurance system that predated the passage of the ACA.[7] Whether consumers fare well or poorly after the ACA will depend on the market behavior of the health insurers selling individual and small group plans. This Article focuses on four aspects of the market behavior of private health insurance plans that have historically caused concern: (1) contractual exclusions of certain categories of care from coverage; (2) utilization review and "medical necessity" judgments; (3) restricted provider networks; and (4) discrimination in plan design and administration.

In Part II, this Article describes explicit contract exclusions. Plans can shape the services they cover by defining what will and will not be covered. The state and federal regulatory structure surrounding the individual and small group markets provides guidance on these coverage terms. Evaluation of the contract terms permits assessment of insurers' fidelity to the existing regulatory requirements. It also will allow an assessment of the extent to which federal and state regulatory structures serve the goals of the ACA, and whether regulatory adjustments are in order.

In Part III, this Article discusses cases in which insurers deny coverage of services because they determine that the services requested are not medically necessary in light of the insured's individual circumstances. These cases are fact specific, but they are subject to internal and external appeals processes that are intended to assure principled, appropriate decisions. Proper medical necessity decision-making approves medically appropriate care and denies inappropriate care. Evaluation of the processes for medical necessity decision-making

5. *See* KATE GREENWOOD ET AL., SETON HALL UNIV. SCH. OF LAW CTR. FOR HEALTH & PHARM. LAW & POLICY, IMPLEMENTING THE ESSENTIAL HEALTH BENEFITS REQUIREMENT IN NEW JERSEY: DECISION POINTS AND POLICY ISSUES iii (Aug. 2012).

6. *See* 45 C.F.R. § 156.235(c) (2014) (requiring that Qualified Health Plans' networks of providers "ensure reasonable and timely access to a broad range of such providers"); *see infra* notes 197–205.

7. *See* Theodore Marmor & Jonathan Oberlander, *The Patchwork: Health Reform, American Style*, 72 SOC. SCI. & MED. 125, 127 (2011).

could provide some indication of plans' willingness to exercise sound discretion.

In Part IV, this Article addresses network adequacy. It is a central function of insurers to create and maintain networks of health care providers who can provide necessary care in a professional, cost-effective, and timely manner. In the interest of holding down premiums, plans have established relatively narrow provider networks. In addition, some have created tiered networks, in which consumer cost-sharing differs by provider tier. These restricted networks can have benefits for consumers, to the extent that they make plans more affordable. They could also, in theory at least, steer consumers to high-quality providers. Restricted networks, however, can also prevent consumers from accessing the providers they need when they need them.

In Part V, this Article addresses the fairness with which plans' terms apply to different classes of insureds. The ACA was intended to end discrimination on the basis of health history, disability, and other characteristics. Discriminatory actions can be overt or subtle. When it arises, discriminatory exclusion from necessary services on the basis of forbidden categories works a double wrong: denial of needed care and harmful discriminatory injury.

Part VI concludes, contending that with regard to all four areas of potential concern, there continues to be a need for monitoring by advocates, federal and state regulators, and others, as well as for targeted enforcement, to ensure that the promise of the ACA is fulfilled. Information derived from monitoring and enforcement should in turn create a feedback loop enabling federal and state policymakers to determine where regulatory reform is needed.

II. CONTRACTUAL EXCLUSIONS FROM COVERAGE

Insurance contracts must define the scope of coverage, and how they are written affects both consumer access to care and notice of what is covered under the policy. One tool insurers have used to limit the care for which they are obligated to pay is to explicitly exclude certain services from coverage in the insurance contract.[8] In some cases, the categories of excluded coverage can be quite broad, such as those excluding "experimental" services.[9] Determining if a once-experimental

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8. *See* Amy Monahan, *Fairness v. Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 200, 218 (2012).

9. *See id.*; *see also* William M. Sage, *Managed Care's Crimea: Medical Necessity, Therapeutic Benefit, and the Goals of Administrative Process in Health Insurance*, 53 DUKE L.J. 597, 605 (2003).

treatment has become medically accepted requires professional assessment and expert judgment.[10]

A second category of exclusions provides more clarity, although it also may raise controversy. Some of the common specific contractual exclusions have included dental care, assisted reproductive technologies, surgical treatment of obesity, and gender transition-related health care, including sex reassignment surgery.[11] These exclusions do not suffer from the indeterminacy problem often attendant to exclusions for experimental treatments. Instead, they raise substantive objections. For example, a common categorical exclusion is that for cosmetic surgery. Many contracts exclude cosmetic surgery on the apparent grounds that insurance need not cover treatments that offer no health benefits, but instead serve the aesthetic preferences of the insured.[12] In some cases, however, it is contestable whether cosmetic surgery ought to be covered. Reconstructive breast surgery following a mastectomy, for example, is clearly "cosmetic," but excluding it invites the higher-order objection that insurance policies ought to include reconstructive surgery following mastectomy for public policy reasons.

A. *Federal and State Efforts to Regulate Contract Exclusions Prior to the Affordable Care Act*

Regulators have responded to contract exclusions by requiring coverage of certain health benefits in the name of maintaining consumer access to appropriate healthcare. Health insurance mandates tend to take three general forms: (1) service or benefit mandates, which require coverage of specific health benefits, such as mammography and prostate cancer screening; (2) provider mandates, which require coverage of particular providers like chiropractors, if coverage is offered for another type of provider, such as physicians; and (3) coverage mandates, which require coverage of identifiable groups such as adopted children, newborns, and domestic partners.[13] Regulators have used mandates to define what insurance contracts must include as a means of advancing consumer protection and public health.

Prior to the ACA, Congress had taken some steps to ensure coverage of specific health care services. In 1996, for example, Congress passed the Newborns' and Mothers' Health Protection Act,

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10. *Id.* at 603–04.

11. *Id.*; *see also* Mark A. Hall, *State Regulation of Medical Necessity: The Case of Weight-Reduction Surgery*, 53 DUKE L.J. 653, 662 (2003).

12. *See* Monahan, *supra* note 8.

13. *See* Tracey A. LaPierre et al., *Estimating the Impact of State Health Insurance Mandates on Premium Costs in the Individual Market*, J. OF INS. REG., at 4–5 (Mar. 1, 2009).

which requires group health plans covering hospital stays related to childbirth to cover at least a forty-eight hour hospital stay for new mothers and their infants.[14] After substantial public debate on the policy reasons for and against precluding coverage, Congress also acted in 1998 to amend the Employee Retirement Income Security Act of 1974 ("ERISA")[15] to mandate coverage for post-mastectomy breast reconstruction.[16]

But given that the states are the primary regulators of commercial insurance, it is not surprising that most mandates are the product of state regulation.[17] Every state has passed benefit mandates, although states vary widely in the number and scope of mandates. While the first recorded state mandate dates back to 1949, many mandates were passed in response to the consumer backlash against managed care in the 1990s.[18] There are varying estimates of the aggregate number of mandates nationally. The Council on Affordable Health Insurance ("CAHI"), for example, estimates that in 2012, the states had an aggregate of 2,271 mandated benefits, with the majority of states having more than forty mandates each.[19] Rhode Island led the states with sixty-nine mandated benefits, whereas Idaho had the least with thirteen.[20]

CAHI's counts include benefit, provider, and coverage mandates as well as so-called "offer" mandates, which merely require plans to *offer* consumers the opportunity to purchase policies that cover particular services, providers, or populations. Offer mandates do not require plans to include these services unless a consumer chooses to purchase that coverage.[21] A 2007 study that excluded offer mandates found an average

14. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVCS., *Newborns' and Mothers' Health Protection Act (NMHPA)*, CMS.GOV, https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpa_factsheet.html (last visited Aug. 9, 2015).

15. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (2012) (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

16. *See* 29 U.S.C. § 1185(b). *See* Cristine Nardi, Comment, *When Health Insurers Deny Coverage For Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WISC. L. REV. 777 (advocating for the passage of federal legislation to mandate insurance coverage for post-mastectomy breast reconstruction).

17. Although states are the primary source of health insurance mandates, they do not have authority to impose mandate requirements on most self-funded plans. *See* LaPierre et al., *supra* note 13, at 6.

18. *See id.* at 4, 6.

19. *See* COUNCIL ON AFFORDABLE HEALTH INS., *CAHI Identifies 2,271 State Health Insurance Mandates* (Apr. 9, 2013), http://www.cahi.org/article.asp?id=1115; VICTORIA CRAIG BUNCE, THE COUNCIL ON AFFORDABLE HEALTH INS., HEALTH INSURANCE MANDATES IN THE STATES 2012: EXECUTIVE SUMMARY 2 (2013).

20. *See* BUNCE, *supra* note 19.

21. LaPierre et al., *supra* note 13, at 4–5; CHERYL ULMER ET AL., ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST 71 n.21 (2012).

of eighteen mandates per state, noting a high of thirty-five in California and a low of two in Idaho.[22] The National Conference of State Legislatures reports that nationally there currently are more than 1,900 state health insurance mandates.[23]

Focusing on benefit mandates that require coverage of specific health services, as of early 2008, the states had adopted 1,088 total benefit mandates requiring coverage of 79 unique benefit mandates.[24] CAHI reports that among the most popular mandates in 2012 were mammography screening (50 states), maternity minimum stay (50 states), breast reconstruction (49 states), mental health parity (48 states), and alcohol and substance abuse treatment (46 states).[25] On the other extreme of the spectrum, breast implant removal, cardiovascular disease screening, circumcision, gastric electrical stimulation, and organ transplant donor coverage each were mandated in only one state.[26]

Mandates are a hotly contested issue in insurance regulation. In addition to the normative claim that mandates unfairly impinge on the right to free contracting, opponents also often make the empirical argument that mandates raise premiums for all consumers, thereby contributing to rates of uninsurance.[27] CAHI, for example, estimates that mandated benefits "increase the cost of basic health coverage from slightly less than 10 percent to more than 50 percent, depending on the state, specific legislative language, and type of health insurance policy."[28]

The Institute of Medicine ("IOM"), however, found that there is "no consensus regarding the price impact of mandates or the effect that any price increase has on coverage rates."[29] To the contrary, evidence suggests that while some mandates contribute to increased premiums, others reduce premiums. One study published in the *Journal of Insurance Regulation* in 2009 found such mixed results when it evaluated the effect of mandates on individual market premiums: while therapeutic services and alternatives to hospitalization were associated with higher premiums, women and children mandates, alternative medicine, emergency services, screening services, physician substitutes,

22. *See* ULMER ET AL., *supra* note 21, at 71.

23. *See* NAT'L CONF. OF ST. LEGISLATURES, *State Health Insurance Mandates and the ACA Essential Benefits Provisions*, http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx (lasted updated June 2014).

24. *See* LaPierre et al., *supra* note 13, at 4.

25. *See* COUNCIL ON AFFORDABLE HEALTH INSURANCE, *supra* note 19.

26. *See id.*

27. *See* ULMER ET AL., *supra* note 21, at 72.

28. COUNCIL ON AFFORDABLE HEALTH INSURANCE, *supra* note 19.

29. ULMER ET AL., *supra* note 21, at 72.

and counseling were associated with lower premiums.[30] The study also showed there was no correlation between the number of mandates a state enacted and premium levels in that state.[31]

In addition, proponents of mandates point out that failing to mandate benefits could also have costs. If a consumer foregoes appropriate care because it is not covered by insurance and then gets sicker, he or she could require more expensive care.[32] Mandates, then, can help achieve health policy goals and correct market failures.[33]

To achieve these positive ends, however, mandates must be medically appropriate. As reported by the IOM, there are concerns "that mandates are not evidence-based and do not always reflect clinical best practices."[34] Although the majority of states require mandate benefit studies before new mandates can be adopted,[35] few states "require prospective, expert analysis of evidence for a mandate before it can be voted on by the legislature."[36] The IOM has lamented that, even where states establish robust review procedures, "there is little evidence that the review procedure leads to evidence-based mandates that significantly improve health outcomes."[37]

As part of ongoing debates about the costs of health care, there have been federal legislative proposals to limit mandates by, for example, permitting the sale of national or statewide plans that would only need to comply with mandates passed by at least forty-five states.[38] To date, these efforts have been unsuccessful, but the debates rage on. As Tracey LaPierre and her colleagues concluded after studying the effect of mandates on premiums, "[m]andates . . . should not be viewed as unambiguously bad or good; careful policy requires separating the wheat from the chaff, but doing so will require more fine-grained work . . . ."[39]

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30. *See* LaPierre et al., *supra* note 13, at 2. The authors note that their findings are not consistent with other research on the effect of mandates, which find both positive and negative effects on premiums and thus call for more research. *See id.* at 29.

31. *See id.* at 4.

32. *See* Michael Bihari, M.D., *Mandated Benefits - Understanding Mandated Health Insurance Benefits Health Benefit Mandates Are Controversial*, ABOUT.COM (updated June 13, 2014), http://healthinsurance.about.com/od/reform/a/mandated_benefits_overview.htm.

33. *See* ULMER ET AL., *supra* note 21, at 72.

34. *Id.*

35. *See* LaPierre et al., *supra* note 13, at 4.

36. *See* ULMER ET AL., *supra* note 21, at 72.

37. *Id.*

38. LaPierre et al., *supra* note 13, at 4.

39. *Id.* at 33.

B. *How the ACA Addresses Contract Exclusions*

To ensure that health coverage is meaningful and medically appropriate, the ACA includes provisions to restrict insurers' ability to exclude vital medical benefits from coverage. Since September 23, 2010, non-grandfathered[40] individual and group health plans must provide preventive health services to enrollees without any cost-sharing when those services are provided by a network provider.[41] The ACA looks to recommendations of the United States Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration to define preventive health services.[42] What is deemed a preventive health service will evolve as evidence becomes available,[43] but currently a variety of services for adults,[44] women,[45] and children[46] are covered, such as blood pressure and depression screening for all adults, specified immunization vaccines for adults and children, breast cancer mammography screenings every one to two years for women over forty, and autism screening for children at eighteen and twenty-four months.[47] Although some plans already provided full coverage of preventive services before the ACA, it is estimated that "approximately 76 million Americans–and 30 million women–are now eligible to receive expanded coverage of one or more preventive services because of the Affordable Care Act."[48]

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40. A "grandfathered health plan" is a plan that was in existence on March 23, 2010, and has not changed in terms of important features including the elimination of benefits for a particular condition, changes in member cost-sharing requirements, or decreased contribution rates by the plan's sponsor. *See* 29 C.F.R. § 2590.715-1251(g) (2015).

41. *See* 42 U.S.C. § 300gg-13 (2012).

42. *See id.*

43. *See, e.g.*, Phil Galewitz, *For High-Risk Women, Some Breast Cancer Drugs To Be Free*, KAISER HEALTH NEWS (Jan. 9, 2014), http://capsules.kaiserhealthnews.org/index.php/2014/01/breast-cancer-drugs-to-be-free-for-high-risk-women/.

44. *See Preventive care benefits: Preventive health services for adults*, HEALTHCARE.GOV, https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults (last visited June 14, 2015).

45. *See*, *Preventive care benefits: Preventive health services for women*, HEALTHCARE.GOV, https://www.healthcare.gov/what-are-my-preventive-care-benefits/women (last visited June 14, 2015).

46. *See Preventive care benefits: Preventive health services for children*, HEALTHCARE.GOV, https://www.healthcare.gov/what-are-my-preventive-care-benefits/children (last visited June, 2015).

47. *Id. See Preventive care benefits: Preventive health services for adults*, *supra* note 44; *Preventive care benefits: Preventive health services for women*, *supra* note

48. AMY BURKE & ADELLE SIMMONS, OFFICE OF THE ASST. SEC'Y FOR PLANNING & EVAL., DEP'T OF HEALTH & HUMAN SERVCS., INCREASED COVERAGE OF PREVENTIVE SERVICES WITH ZERO COST SHARING UNDER THE AFFORDABLE CARE ACT 2, 4 (June 27, 2014).

Beginning in 2014, the ACA also requires non-grandfathered health insurance plans offered in the individual and small-group markets, both on- and off-exchange, to offer a slate of ten essential health benefits.[49] These benefits are equal to the scope of benefits provided under a typical employer plan: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services that include oral and vision care.[50]

By itemizing EHB categories, Congress was aiming to ensure that individual and small-group plans would offer uniform, comprehensive coverage.[51] But Congress left it to the Secretary of the U.S. Department of Health and Human Services ("HHS") to define the content of each category and establish a system for monitoring and enforcement, subject to statutory requirements.[52] For nearly two years following the passage of the ACA, both public and private entities, including the IOM, Department of Labor, the Mercer consulting firm, and HHS itself, invested considerable effort to flesh out the specific contours of the ten general EHB categories.[53] The expectation was that HHS would establish a national standard for EHB, as suggested by the IOM.[54]

But the Secretary surprised many by choosing, at least for plan years 2014 and 2015, to devolve much of the task of defining EHB to the states.[55] States have the opportunity to select a benchmark plan from a menu of existing health care plans identified by HHS, namely: (1) the largest plan by enrollment in any of the state's three largest small-group insurance products; (2) any of the largest three state employee health benefit plans by enrollment; (3) any of the three national Federal Employees Health Benefits Program ("FEHBP") plan options by enrollment; or (4) the largest insured commercial non-Medicaid HMOs

49. *See* 42 U.S.C. §§ 300gg-6(a), 18022 (2012). The ACA also includes EHB provisions that apply only to qualified health plans. *See, e.g.*, 42 U.S.C. § 18022(b)(4)(E) (requirements regarding emergency department services); 42 U.S.C. § 18022(b)(4)(F) (recognizing an exception for QHPs that do not offer pediatric oral coverage when the same exchange offers a standalone pediatric dental option).

50. *See* 42 U.S.C. §§ 300gg-6(a), 18022.

51. *See* JUSTIN GIOVANNELLI ET AL., THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: REVISITING THE ACA'S ESSENTIAL HEALTH BENEFITS REQUIREMENTS 1 (Oct. 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/oct/1783_giovannelli_implementing_aca_essential_hlt_benefits_rb.pdf.

52. *See* 42 U.S.C. § 18022(b); *see generally* Greenwood et al., *supra* note 5.

53. *See* GREENWOOD ET AL., *supra* note 5, at 5–6.

54. *See* ULMER ET AL., *supra* note 21, at 6.

55. *See* GIOVANNELLI ET AL., *supra* note 51.

operating in the State.[56] The default benchmark in states that decline to select a benchmark is "the largest plan by enrollment in the largest product by enrollment in the State's small-group market."[57] Where the benchmark plan does not include services from each of the ten EHB categories, states must supplement it, as detailed in the implementing regulations.[58] Carriers have the option to adopt the benchmark plan or to make actuarially equivalent substitutions to benefits within each EHB category in the benchmark to create a substantially equal package of benefits with regard to "both the scope of benefits offered and any limitations on those benefits[,] such as visit limits."[59] Regardless of the benchmark selected, EHB is deemed to include the preventive health services that are required to be provided without cost-sharing, as discussed above.[60]

C. *Next Steps for Coverage Regulation*

There are a number of open issues related to EHB implementation. HHS's interim implementation approach rests on benchmarks sold in the states prior to the ACA. Many pre-ACA plans were covering services in many of the EHB categories.[61] But if the prior system had been working well, there would have been little reason for Congress to legislate EHB requirements. HHS identified three of the ten EHB categories for which coverage varied considerably among plans and markets prior to the EHB requirement and that pose potential implementation challenges: mental

56. *See* 45 C.F.R. § 156.100(a) (2014).

57. *Id.* § 156.100(c).

58. *See id.* § 156.110(b); *see also id.* § 156.110(c) (regarding supplementing default benchmark plans).

59. CTRS. FOR MEDICARE & MEDICAID SERVS., DEP'T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN 5 (Feb. 17, 2012), http://www.cms.gov/CCIIO/Resources/Files/Downloads/ehb-faq-508.pdf [hereinafter EHB FAQ]; *see* 45 C.F.R. § 156.115(a)(1) & (b). Plans may not make substitutions to prescription drug benefits, however. *See id.* § 156.115(b)(1)(iii).

60. *See* 45 C.F.R. § 156.115(a)(4); EHB FAQ, *supra* note 59, at 5. It is interesting to note that although the thrust of the ACA's EHB provisions was to require coverage of a core set of health care services, the implementing regulations exclude categories of coverage from EHB. *See* 45 C.F.R. § 156.115(d). Specifically, "EHB may not include routine non-pediatric dental services, routine non-pediatric eye exam services, long-term/custodial nursing home care benefits, or non-medically necessary orthodontia . . . ." *Id.* As discussed below, prescription drug benefits also have received special attention, with the Secretary specifying what formulary is adequate for health plans required to comply with EHB requirements.

61. *See* Timothy Jost, *Implementing Health Reform: The Essential Health Benefits Final Rule*, HEALTH AFFAIRS BLOG (Feb. 20, 2013), http://healthaffairs.org/blog/2013/02/20/implementing-health-reform-the-essential-health-benefits-final-rule/.

health and substance use disorder services, pediatric oral and vision services, and habilitative services.[62]

Although plans generally cover mental health and substance use disorder services, HHS found that small-group plans tend to limit the extent of this coverage.[63] HHS found that it was unclear from summary plan documents whether plans cover behavioral health treatment ("BHT"), which is part of EHB.[64] It also found that, in general, BHT for autism tended to be covered only when there was a corresponding state mandate.[65] As discussed in more detail below, HHS since has promulgated regulations making clear that a health plan will not be deemed to provide EHB unless the benefits it offers comply with the Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA").[66] It will be important to monitor how plans are implementing this EHB category, including the scope of coverage plans are providing and the extent to which plan networks have the capacity to provide the care that now is covered.[67]

Pediatric dental is another EHB category that presents challenging implementation issues. The ACA singled out pediatric dental coverage by requiring exchanges to permit limited scope dental benefit plans that satisfy statutory requirements to be sold either as stand-alone dental plans or in conjunction with qualified health plans ("QHPs").[68] Although stand-alone dental plans must comply with a number of QHP certification standards, many of the ACA's consumer protection provisions have been modified or deemed inapplicable to stand-alone dental plans, such as rating rules and medical loss ratio requirements.[69]

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62. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN, 5–6 (Dec. 16, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf [hereinafter EHB BULLETIN].

63. *See id.*

64. *See id.*

65. *See id.*

66. *See* 45 C.F.R. § 156.115(a)(3) (citing 45 C.F.R. § 146.136).

67. *See infra* Part IV.

68. *See* 42 U.S.C. § 18031(d)(2)(B)(ii) (2012); 45 C.F.R. § 155.1065(b); *see generally* 42 U.S.C. § 18021(defining qualified health plans).

69. *See* Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs, for Medicare & Medicaid Servs., to Issuers in the Federally Facilitated Marketplaces, at 31–32 (Mar. 14, 2014),https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf, [hereinafter CMS, *2015 Letter to Issuers*]; Letter from Ctr. for Consumer Info. & Ins. Oversight, Ctrs. for Medicare & Medicaid Servs., to Issuers on Federally-facilitated and State Partnership Exchanges, at 29–33 (Apr. 5, 2013), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf [hereinafter CMS, *2013 Letter to Issuers*]; ANDREW SNYDER ET AL., NATIONAL ACADEMY FOR STATE HEALTH POLICY, IMPROVING INTEGRATION OF DENTAL HEALTH BENEFITS IN HEALTH INSURANCE MARKETPLACES 11 (Apr. 2014).

When a limited scope dental plan is available through an exchange, that exchange may certify a plan that does not include pediatric dental coverage as a QHP.[70] But since the ACA requires exchange plans *to offer* EHB coverage but does not require consumers *to buy* the full panoply of EHB benefits through an exchange,[71] exchange consumers may forego purchasing the stand-alone plans that provide pediatric coverage,[72] which undermines the policy goal of expanding access to pediatric dental coverage. Although such limited-scope dental plans are subject to their own out-of-pocket cost-sharing limitations,[73] these out-of-pocket cost-sharing amounts are not included in calculations for cost-sharing subsidies,[74] which heightens the risk that QHP purchasers will bypass stand-alone dental plans. Moreover, if a state's second-lowest cost silver plan does not include pediatric dental benefits, the cost of dental coverage is not included in the calculation used to establish advanced premium tax credits.[75] It is not surprising, then, that a study by the American Dental Association found that only 34 percent of federal exchange health plans included pediatric dental benefits, and only 63,448 of the estimated six to eight million children eligible for coverage signed up for stand-alone dental plans sold through the federal website in thirty-six states.[76] To ensure children receive this essential health benefit, as Congress intended, it is critical to monitor and evaluate how the different benefit designs for the pediatric dental benefit work in practice and what regulatory options are available.[77]

HHS noted that there is uncertainty regarding what services are included within the habilitative care EHB category.[78] Prior to the ACA, few plans identified services using this label, and there is no universally

70. *See* 42 U.S.C. § 18022(b)(4)(F); 45 C.F.R. § 155.1065(d); *see also* N.J.A.C. § 11:20, Appx., Exhibit C (LexisNexis 2015) ("For policies sold on the Marketplace the Dental Benefits provision may be excluded if the Marketplace offers a standalone dental plan with a pediatric dental essential health benefit. . . .").

71. *See* 42 U.S.C. § 300gg-6(a).

72. *See* Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,853 (Feb. 25, 2013).

73. *See* 45 C.F.R. § 156.150(a).

74. *See* 42 U.S.C. § 18071(c)(5); 45 C.F.R. § 156.440(b); SNYDER ET AL., *supra* note 69, at 5.

75. SNYDER ET AL., *supra* note 69, at 15.

76. *See* Marissa Evans, *Many kids fall through gaps in dental care*, USA TODAY, May 17, 2014, http://www.usatoday.com/story/news/nation/2014/05/17/kids-dental-plans/9098439/.

77. *See, e.g.*, Joe Touschner, *Time for a Dental Check Up*, GEORGETOWN CTR ON HEALTH INS. REFORMS BLOG (Mar. 14, 2014), http://ccf.georgetown.edu/all/time-for-a-dental-check-up/.

78. EHB BULLETIN, *supra* note 62, at 11.

accepted definition of these services.[79] Initially, while HHS wrestled with how to define habilitative services, it implemented a transitional policy that let states determine what services to include in their benchmark plans for this EHB category.[80] In states that did not define habilitative services, issuers had a choice among two options.[81] Plans could offer habilitative services at parity with rehabilitative services "by covering habilitative services benefits that are similar in scope, amount, and duration to benefits covered for rehabilitative services."[82] Alternatively, issuers could define what constitutes habilitative services and report the definition they employed to HHS, which would consider the matter.[83]

Noting that this transitional policy had not always "resulted in comprehensive coverage for habilitative services," HHS adopted a uniform definition of habilitative services in its Notice of Benefit and Payment Parameters for 2016 Final Rule:[84]

> (a) Provision of EHB means that a health plan provides benefits that . . .
>
> (5) With respect to habilitative services and devices—
>
> (i) Cover health care services and devices that help a person keep, learn, or improve skills and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings;
>
> (ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

79. *See id.* at 6.

80. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,834–35 (Feb. 25, 2013); 45 C.F.R. § 156.110(f) (2014).

81. *See* Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. at 12,843–44.

82. 45 C.F.R. § 156.115(a)(5)(i).

83. *Id.* § 156.115(a)(5)(ii).

84. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,811 (Feb. 27, 2015).

(iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.[85]

HHS also eliminated the provision that had permitted insurance companies to determine the scope of habilitative services.[86] States, however, retain the ability "to determine services included in the habilitative services and devices category if the base-benchmark plan does not include coverage."[87] It will be important to assess whether this definition furthers HHS's goal of minimizing "the variability in benefits and lack of coverage for habilitative services."[88] .

There also has been debate over how HHS should implement the prescription drug coverage EHB category. Initially, HHS intended to permit a plan to select the specific drugs it would offer in its formulary as long as the plan covered at least one drug in each category or class of drugs included in the benchmark.[89] This proposal sounded alarms for some, like Professor Kenneth Thorpe, who described it as "unnecessarily restrictive" and predicted it "would be catastrophic[,]" because "[m]edicines are not interchangeable."[90]

When it initially finalized the rules, HHS required issuers to cover "at least the greater of: (i) [o]ne drug in every United States Pharmacopeia (USP) category and class; or (ii) [t]he same number of

85. 45 C.F.R. § 156.115(a)(5); *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,811. ("Habilitative services, including devices, are provided for a person to attain, maintain, or prevent deterioration of a skill or function never learned or acquired due to a disabling condition. Rehabilitative services, including devices, on the other hand, are provided to help a person regain, maintain, or prevent deterioration of a skill or function that has been acquired but then lost or impaired due to illness, injury, or disabling condition.").

86. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10, 811.

87. *Id.*

88. *Id.*

89. EHB BULLETIN, *supra* note 62, at 12–13.

90. Kenneth Thorpe, *Determining "Essential" Health Benefits*, HILL'S CONGRESS BLOG (June 20, 2012 5:46 P.M. EST), http://thehill.com/blogs/congress-blog/healthcare/233841-determining-essential-health-benefits; *see also* Colorado Consumer Health Initiative, Comments on Patient Protection and Affordable Care Act; Data Collection to Support Standards Related to Essential Health Benefits; Recognition of Entities for the Accreditation of Qualified Health Plans, at 3 (July 5, 2012), http://www.regulations.gov/contentStreamer?documentId=CMS-2012-0071-0036&attachmentNumber=1&disposition=attachment&contentType=pdf (contending that the Affordable Care Act requires that the EHB package be comparable to a typical employer plan, which means that the EHB package will have to cover "a broad range of drugs . . . within each category or class").

prescription drugs in each category and class as the EHB-benchmark plan."[91]

In its Notice of Benefit and Payment Parameters for 2016 Final Rule, HHS implemented a number of revisions to its EHB prescription drug coverage policy.[92] While preserving the USP drug count standard, the agency required plans beginning on or after January 1, 2017, to establish a pharmacy and therapeutics (P&T) committee.[93] The regulation establishes a number of standards for the P&T committee, including that it must:

> Ensure the issuer's formulary drug list:
>
> (1) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees; and
>
> (2) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.[94]

The P&T committee also is charged with reviewing "policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange," and reviewing and approving "all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug."[95]

HHS believes that the combination of a P&T committee and the USP drug count standard will "ensure that the plan's formulary drug list covers a sufficient number and type of prescription drugs."[96] States are responsible to oversee and enforce P&T committee standards and the USP drug count standard.[97] HHS indicated that it may develop "tools and resources to assist States in reviewing formulary drug lists."[98] It is critical to evaluate if HHS's revised policy provides consumers with

91. *See* 45 C.F.R. § 156.122(a)(1) (2014). Health plans also must "have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan." *Id.* § 156.122(c).

92. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,813–19.

93. *See* 45 C.F.R. § 156.122(a)(3).

94. *Id.* § 156.122(a)(3)(iii)(H).

95. *Id.* § 156.122(a)(3)(iii)(D)&(F).

96. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,813.

97. *See id.* at 10,814–15.

98. *Id.* at 10, 815.

access to medically appropriate prescription drug coverage as Congress intended.[99]

Although the ACA prohibits annual and lifetime dollar limits on EHB,[100] HHS is permitting such limits to "be converted to actuarially equivalent treatment or service limits."[101] The American Academy of Pediatrics has expressed concern that "the new EHB data collection structure will not make it possible to verify the actuarial equivalence of treatment limits, and in particular, non-quantitative limits," which "could result in some plans using non-quantitative limits to reduce access to benefits while still appearing to be actuarially equivalent to the benchmark plan."[102] Timothy Jost similarly has warned that "[t]his will substantially undermine the dollar limit prohibition."[103] Such substitutions also make it more difficult for consumers to compare plans. It is important to monitor if plans are introducing treatment or service limits as a substitute for dollar limits on EHB and, to the extent they are, if there are ways to improve transparency for consumers.

Another interesting policy question is how HHS will decide to handle the costs for state mandates that exceed the requirements of EHB in QHPs. The ACA requires states to make payments to or on behalf of individuals in QHPs to defray the costs of benefits required by state law that are in addition to EHB.[104] To "accommodate[ ] current market offerings and limit[ ] market disruption in the first years of the Exchanges," HHS has adopted a transitional policy for at least plan years 2014–2016.[105] Pursuant to HHS's policy, the agency will not consider a state-required benefit that was enacted on or before December 31, 2011,

99. *See, e.g.*, Part V(D)(1), *infra* (discussing prescription drug tiering).

100. *See* 45 C.F.R. § 147.126 (2014).

101. CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID STUDIES, ADDITIONAL INFORMATION ON PROPOSED STATE ESSENTIAL HEALTH BENEFITS BENCHMARK PLANS, CMS.GOV, http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html (last visited Aug. 8, 2014); *see also* EHB FAQ, *supra* note 59, at 4.

102. Letter from Robert W. Block, President, American Academy of Pediatrics, to Marilyn A. Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services, at 2 (July 5, 2012), http://www.regulations.gov/#!documentDetail;D=CMS-2012-0071-0051.

103. Timothy Jost, *Implementing Health Reform: Essential Health Benefits And Medical Loss Ratios*, HEALTH AFFAIRS BLOG (Feb. 18. 2012), http://healthaffairs.org/blog/2012/02/18/implementing-health-reform-essential-health-benefits-and-medical-loss-ratios/.

104. *See* 42 U.S.C. § 18031(d)(3)(B) (2012).

105. *See* 45 C.F.R. § 155.170(a)(2); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,838 (Feb. 25, 2013); Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015)

to be in addition to the essential health benefits.[106] It will be important for states to monitor HHS's decision because, if HHS alters this policy, states may need to make payments to defray the cost of mandated benefits that go beyond the coverage required by EHB.

There also is some confusion surrounding what health services qualify as preventive services. There have been reports that patients have scheduled annual physicals, expecting them to be covered at one hundred percent.[107] But if patients report at these visits that they have been experiencing headaches or that they are depressed, the visit may no longer be considered preventive, which would trigger a copay from the patient.[108] Many patients, for example, have received bills for polyp removal performed during screening colonoscopies, even though the screening colonoscopy itself is a preventive health service that should be covered without any cost-sharing.[109] A study by Karen Pollitz and others found inconsistent insurer definitions of what constitutes a covered screening service as well as non-standard billing code practices of insurers and providers.[110] Although consumer and provider education surely could help the situation, confusion may be inevitable, given that what constitutes preventive health services is likely to evolve as new research is conducted.

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106. *See* 45 C.F.R. § 155.170(a)(2); Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. at 12,838; *see also* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,813 ("We did not propose any changes to §155.170. Therefore, only new State-required benefits enacted on or prior to December 31, 2011 are included as EHB, and States are expected to continue to defray the cost of State-required benefits enacted on or after January 1, 2012 unless those State-required benefits were required in order to comply with new Federal requirements. HHS intends to continue to publish a list of non-EHB State-required benefits on its Web site on an annual basis."); *id.* at 10,811–11 (explaining that States are not required to defray the cost of State laws enacted to comply with the habilitative services EHB requirement because "State laws enacted in order to comply with § 156.110(f) are not considered benefits in addition to the EHB; such laws ensure compliance with § 156.110(a) which requires coverage of all EHB categories").

107. *See* Melinda Beck, *Discord Over What to Pay the Doctor*, WALL ST. J. ONLINE (Apr. 13, 2014 7:33 p.m.), http://online.wsj.com/news/articles/SB10001424052702304058204579495552393406252.

108. *See id.*

109. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., *Affordable Care Act Implementation FAQs - Set 12*, CMS.GOV, https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html (last visited Aug. 9, 2015).

110. *See* KAREN POLLITZ ET AL., COVERAGE OF COLONOSCOPIES UNDER THE AFFORDABLE CARE ACT'S PREVENTION BENEFIT 3 (Sept. 2012), http://kaiserfamilyfoundation.files.wordpress.com/2012/08/8351-coverage-of-colonoscopies-under-the-affordable-care-act.pdf.

Although EHB requirements partially respond to contract exclusions, they do not eliminate them. Indeed, health insurance contracts continue to contain exclusions. HealthPocket found that the ten most commonly excluded medical services in individual market plans in 2014 were: long-term care (99 percent), cosmetic surgery (92 percent), adult dental services (89 percent), weight loss programs (88 percent), acupuncture (84 percent), routine foot care (72 percent), infertility treatment (67 percent), private nursing (67 percent), adult eye exams (61 percent), and weight loss surgery (59 percent).[111] Interestingly, 80 percent of these services also were in the top ten list of exclusions in 2013, before the EHB requirements went into effect–children's eyeglasses and children's dental checkups dropped off the list, making room for routine foot care and adult eye exams to join.[112] Although most excluded services continue to be excluded post-EHB, the study noted that weight loss programs dropped from being excluded by 93 percent of the plans in 2013 to 88 percent in 2014, that weight loss surgery had been excluded by 90 percent and now was excluded by only 59 percent of plans, and that infertility treatment went from being excluded by 94 percent down to 66 percent of health plans.[113] It is important to monitor contract exclusions as well as potential blurred lines between covered and excluded categories of care to assess if greater clarity is needed regarding the boundaries of each to minimize consumer confusion.

Underlying each of these issues is the persistent need, as HHS has recognized, "to balance comprehensiveness, affordability, and State flexibility."[114] In February 2015, HHS announced that it will continue to use the benchmark process to determine EHBs through plan year 2017 because this approach is the most appropriate way to "[m]aintain State flexibility while ensuring comprehensive coverage."[115] The agency will be examining "how the policy affected enrollees and what changes, if any, should be made in the future."[116] States, too, should evaluate their regulatory options.[117]

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111. *See Top 10 Healthcare Services Excluded Under Obamacare*, HEALTHPOCKET.COM (Feb. 26, 2014), http://www.healthpocket.com/healthcare-research/infostat/top-10-excluded-services-obamacare#.U-UFgvldV8E.

112. *See id.*

113. *See id.*

114. EHB BULLETIN, *supra* note 62, at 1.

115. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015).

116. *Id.*

117. *See, e.g.*, JUSTIN GIOVANNELLI ET AL., THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: STATE ACTION TO REFORM THE INDIVIDUAL HEALTH INSURANCE MARKET (July 2014), http://www.commonwealthfund.org/~/media/files /publications/issue-

III. UTILIZATION REVIEW AND "MEDICAL NECESSITY" JUDGMENTS

As discussed in the prior section, insurance contracts broadly cover a wide range of services such as hospitalization, physician services, pharmaceuticals, and diagnostic technologies.[118] Within those broad categories of coverage, however, insurance contracts invariably limit care to that which is "medically necessary."[119] Once a person is insured, and that insurance covers particular services essential to the person's health, disputes may arise over whether a covered service is medically necessary in the situation in which the person finds herself. The ACA builds on prior law to improve the processes by which medical necessity decisions are made.

There is no straight-forward, generally accepted definition of medical necessity.[120] An insurer's refusal to pay for services on medical necessity grounds connotes a judgment that the treatment is not, in the case at hand, medically appropriate.[121] The leading insurance treatise summarizes the contractual bases for medical necessity denials as follows:

> The insurer may . . . delineate criteria for determining what is medically necessary in the policy. For example, a policy may define a "medically necessary" treatment as one which is (1) required and appropriate for care of the sickness or the injury, (2) given in accordance with generally accepted principles of medical practice in the United States at the time furnished, (3) approved for reimbursement by the Health Care Financing Administration [now CMS], (4) not deemed experimental, educational, or investigational in nature by any appropriate technological assessment body

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brief/2014/jul/1758_giovannelli_implementing_aca_state_reform _individual_market_rb.pdf (examining where states have flexibility to enact consumer protections that exceed federal minimum requirements).

118. *See supra* Part II.A–B.

119. *See* Sage, *supra* note 9, at 605–06 (describing the history and function of "medical necessity" determinations in health insurance contracts).

120. *See, e.g.*, ULMER ET AL., *supra* note 21, at 95 (declining to articulate a definition for medical necessity, instead deferring to industry practice: "Medical necessity is a condition of benefit coverage usually found in insurance contracts, allowing health insurers to review the appropriateness of any intervention a patient receives"); Sage, *supra* note 9, at 601–02; Mark A. Hall & Gerald F. Henderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1646–48 (1992).

121. This suggested working definition of "medical necessity" is not intended to paper over the fact that the term is used in many ways in many circumstances. Professor William Sage has reported on a Stanford University study that asked plan decision-makers to distinguish between a "'medical necessity decision' and a 'coverage decision'" found that there was a wide range of responses. Sage, *supra* note 9, at 603–04.

> established by any state or federal government, and (5) not furnished in connection with medical or other research.[122]

None of those categories provides a bright-line interpretive standard. Medical necessity review permits health insurers a contractual mechanism for reviewing some[123] cases prior to approval ("prospective review") or after treatment ("retrospective review") to exclude coverage for treatment that is beyond the terms of the contractual agreement, as the insurer interprets it.

Contract language can be more clearly specified on what services are covered and which are excluded, so that the insureds can more fully understand the nature of their bargain when they purchase particular health insurance coverage.[124] The infinite complexity of human medical conditions and the range of possible treatments, however, guarantee that no contractual language can resolve all disputes. Interpretive disputes can arise regardless of the thoroughness and thoughtfulness of the contractual drafting process.

Attempts to articulate principles to guide medical necessity judgments have focused on several principles. First, a touchstone for interpretation has been customary medical practice.[125] Second, the treatment sought must be "effective" in treating illness or injury.[126] Third, it must not be provided merely "as a convenience to the patient or provider."[127] These principles are intended to rule out coverage in cases where treatment is simply outside accepted professional norms, not matched to the underlying health condition such that its provision is calculated to provide medical benefit, or predominantly a social amenity rather than a health care treatment.

Medical necessity clauses, then, can serve the salutary purpose of setting out a boundary around insurance coverage, permitting principled limits to insurers' financial exposure.[128] Their use can also be problematic, as the inherent indeterminacy of medical necessity judgments can leave both insurer and insured uncertain of their rights

122. STEVEN PLITT ET AL., COUCH ON INSURANCE § 181:2 (3D ED. 2013) (citations omitted).

123. Hall and Henderson report that resort to medical necessity denials comprises a small percentage of claims – "only one to two percent." Hall & Henderson, *supra* note 120, at 1654 (citing INST. OF MED., CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 4, 77 (Bradford H. Gray & Marilyn J. Field eds., 1989)). *See* Part III(C)(1), *infra*.

124. *See* Part II, *infra*.

125. Linda A. Bergthold, *Medical Necessity: Do We Need It?*, 14 HEALTH AFF., Nov. 1995, at 180, 182.

126. *Id.* at 182–83.

127. *Id.*

128. Hall & Henderson, *supra* note 120, at 1653–54.

and obligations.[129] Treatments seen by some as speculative experiments can be seen by others as proper cutting-edge care. Treatment with little predicted efficacy might be seen in a more favorable light in cases of grave illness that is unresponsive to other therapies.[130] There is even a risk, as described below, that the indeterminacy of medical necessity judgments could permit disparate treatment of vulnerable groups.[131]

Some uncertainty is sure to remain, regardless of attempts to narrow its range.[132] Take, for example, the case of an item of durable medical equipment. Some consumers with mobility impairments benefit from the use of "power operated vehicles," or scooters, to go about their daily lives. Disputes can arise, however, over whether the scooter is "medically necessary" or a "convenience" item.[133] No amount of contractual language refinement can avoid differing, plausible interpretations of coverage in all such cases. Dispute resolution procedures therefore are necessary.[134]

A. Dispute Resolution Procedures

Civil litigation has been the historic resolution procedure for medical necessity disputes. The litigation can be premised on state contract law theories, in which courts are asked to settle disputes over insurers' contractual obligations.[135] Where coverage is an incident of employment, ERISA, a federal statute governing employee benefits, usually shifts the legal focus from state contract law to federal law.[136]

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129. Sage, *supra* note 9, at 601–02; Bergthold, *supra* note 125, at 186–87.

130. Sara J. Singer & Linda A. Bergthold, from the Stanford Center for Health Policy, conducted a series of interviews of medical directors of managed care plans over a decade ago to investigate the means by which these directors made medical necessity judgments. They discovered that the contractual language did not drive their decision-making process to the extent contract drafters might hope. Sara J. Singer & Linda A. Bergthold, *Prospects For Improved Decision Making About Medical Necessity*, 20 HEALTH AFF., Jan. 2001, at 200, 202.

131. *See infra* Part V.

132. *See* Sage, *supra* note 9, at 598–99.

133. *See* Lisa Iezzoni, *Boundaries: What happens to the disabled poor when insurers draw a line between what's "medically necessary" and devices that can improve quality of life?*, 18 HEALTH AFF., Nov. 1999, at 171, 174.

134. *See* HUSKY HEALTH CONNECTICUT, *HUSKY Health Wheeled Mobility Letter of Medical Necessity Form* (May 1, 2015), http://www.huskyhealthct.org/providers/provider_postings/policies_procedures/wheeled_mobility/Wheeled_Mobility_Device_Guidelines_Instructions.pdf (form provided by HUSKY Health, which houses Connecticut's Medicaid program, for insureds to appeal medical necessity denials of motorized scooters).

135. *See* Sage, *supra* note 9, at 610–11.

136. Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (2012) (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.). Most employment-based coverage is

Whether litigation proceeds under state contract causes of action (usually in state court) or under ERISA causes of action[137] (usually in federal court), a court's ultimate judgment typically will depend on fact-specific analysis of the coverage requested and opposing opinions on the medical necessity of that treatment.[138] The litigation process has been criticized as expensive and time-consuming, leading to inconsistent determinations by lay judges and jurors.[139]

In the 1990s and 2000s, as part of the backlash against managed care, consumers pushed back against medical denials by plans.[140] Federal and state regulators supplemented the expensive and lengthy litigation process with more accessible and timely processes of internal and external appeals.[141] The internal appeals processes commonly came to have two stages, with the first stage consisting of review by a plan physician not involved in the initial medical denial, and the second stage consisting of another internal appeal, this time to a committee comprising clinicians, non-clinical plan employees, and in some cases, community representatives.[142] To the extent plans had not been required by preexisting state law to provide internal review processes, the ACA now requires, as a matter of federal law, non-grandfathered plans to offer internal appeals.[143]

Skepticism of insurers' internal review of medical necessity denials led many states to implement an external "independent utilization review" process that permitted the insureds to seek review of denials

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affected by ERISA and its preemption provisions. Coverage not affected by ERISA includes individually-purchased coverage, public benefits (*e.g.*, Medicare and Medicaid), and employment-based benefits for government employers and some church organizations. *See* 20 U.S.C. § 1002.

137. ERISA preemption bars state-law contract actions for most employment-based coverage disputes. 29 U.S.C. §§ 1132, 1144. *See* Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 55 (1987). Most Americans with private insurance have it as an incident of employment. *See* HUBERT JANICKI, UNITED STATES CENSUS BUREAU,EMPLOYMENT-BASED HEALTH INSURANCE: 2010 1 (Feb. 2013).

138. *See* PLITT ET AL., *supra* note 122, § 181:2.

139. *See generally* Sage, *supra* note 9; Hall & Henderson, *supra* note 120.

140. *See* James C. Robinson and Jill M. Yegian, *Medical Management After Managed Care,* HEALTH AFF. (WEB EXCLUSIVE), May 2004, at W4-269, W4-269, http://content.healthaffairs.org/content/early/2004/05/19/hlthaff.w4.269.full.pdf; James Robinson, *The End of Managed Care,* 285 JAMA 2622, 2622 (2001).

141. *See* Gresenz et al., *Patients in Conflict with Managed Care: A Profile of Appeals in Two HMOs,* 21 HEALTH AFF. July 2002, at 189, 189; Susan J. Stayn, Note, *Securing Access to Care in Health Maintenance Organizations: Toward a Uniform Model of Grievance and Appeal Procedures,* 94 COLUM. L. REV. 1674, 1702–06 (1994).

142. *See* Aaron Seth Kesselheim, Comment, *What's the Appeal? Trying to Control Managed Care Medical Necessity Decisionmaking Through a System of External Appeals,* 149 U. PA. L. REV. 873, 884–85 (1992).

143. *See* 45 C.F.R. §§ 147.136(a)–(b) (2014).

from panels of independent, suitably qualified physicians.[144] These private independent utilization review organizations ("IUROs") "contract with states [and/or] private health plans . . . to conduct external reviews. These organizations in turn contract with practicing physicians from many specialties who agree to be available to review cases."[145] Although prior to the ACA, most plans subject to state regulation were required to provide independent external appeals as a matter of state law,[146] the ACA requires that all non-grandfathered individual and group health insurance plans provide external review as a matter of federal law.[147]

Independent review processes have been increasingly favored over private litigation and internal review processes for several reasons. First, they shift clinical judgment from plan employees to independent clinical reviewers, thereby addressing concerns about decision-maker conflicts of interest.[148] Second, they are less formal, less expensive, and less time-consuming than litigation in state or federal courts.[149] Third, they place decision-making authority over largely clinical decisions in the hands of specialized physicians, and not lay judges or juries, thereby permitting the application of clinical expertise to medical necessity judgments.[150]

Internal and external review procedures are not, of course, panaceas. Internal review provides an opportunity for reconsideration of plans' decisions and allows for a fuller consideration of the appropriateness of the circumstances surrounding the requested treatment.[151] Internal review, however, can be opaque and subject to conflicts of interest.[152]

Independent review process can correct the structural conflicts of interest to which internal appeals are subject without entailing the cost and delays inherent in litigation.[153] States have attempted to strike a balance between consumer-friendly, simple processes and procedures ensuring sound decision-making. These goals have been impeded in

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144. *Id.*

145. GERALDINE DALLEK & KAREN POLLITZ, HENRY J. KAISER FAMILY FOUND., EXTERNAL REVIEW OF HEALTH PLAN DECISIONS: AN UPDATE 8 (May 2000) http://kaiserfamilyfoundation.files.wordpress.com/2013/01/external-review.pdf.

146. *See id.*

147. *See* 45 C.F.R. § 147.136(d) (setting out requirements for external review for non-grandfathered self-funded plans governed by ERISA); U.S. DEP'T OF LABOR, TECHNICAL RELEASE NO. 2011-02 (June 22, 2011) (providing further standards for external review for non-grandfathered plans governed by ERISA), http://www.dol.gov/ebsa /newsroom/tr11-02.html#f12.

148. *See* Kesselheim, *supra* note 142, at 886.

149. *See* Sage, *supra* note 9, at 620.

150. *See id.;* Gresenz et al., *supra* note 141, at 189.

151. *See* Kesselheim, *supra* note 142, at 883.

152. *See id.* at 884–85.

153. *See* Gresenz et al., *supra* note 141, at 189–90.

some instances by continued shortcomings: (1) it is sometimes subject to shorter filing deadlines than are civil actions in courts;[154] (2) it requires exhaustion of often multi-level internal appeals (with exceptions or expedited processes for emergency cases);[155] (3) while the independent review process is simpler than litigation, it nevertheless can be time-consuming, as the patients and their health care providers must gather and submit medical records and other information in support of the review;[156] (4) few sources of assistance exist for patients pursuing the process;[157] and (5) "medical necessity" remains a murky concept during the process, and even conflict-free expert physicians can disagree on its definition in any case.[158]

B. *The Numbers: Denials, Appeals, Reversals*

Medical necessity judgments attempt to determine whether insurance resources should be expended on care in particular contexts in which the application of coverage terms to a patient's condition is contestable.[159] There apparently are no data sources gathering insurance companies' or plan administrators' denial rates.[160] RAND Corporation researchers examined past studies and found indications of enormous numbers of claims denials.[161] They reviewed reports from the American Medical Association and an electronic billing service, which disclosed plan-specific rates of denials ranging from one percent to fifteen percent for private insurers, with even higher rates in Medicaid plans.[162] These

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154. *See* DALLEK & POLLITZ, *supra* note 145, at 5.

155. *See* Leatrice Berman-Sandler, *Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability*, 13 ANNALS HEALTH L. 233, 247–49 (2004); DALLEK & POLLITZ, *supra* note 145, at 4.

156. *See* DALLEK & POLLITZ, *supra* note 145, at 4–6.

157. The ACA contemplated the creation in each state of offices of insurance ombudsman and Consumer Assistance Programs ("CAPs") with the purpose, *inter alia*, of assisting consumers in the filing of internal and external appeals. 42 U.S.C. § 300gg–93(c) (2012). Lack of state take-up and shortfalls in funding, however, have limited these programs. As of August 10, 2014, there are only twelve federally funded CAP programs operating in nine states, the District of Columbia, and two territories. *See* CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., *Consumer Assistance Program*, http://www.cms.gov/CCIIO/Resources/Consumer-Assistance-Grants/ (last visited Aug. 10, 2014).

158. *See* Berman-Sandler, *supra* note 155, at 247–49; DALLEK & POLLITZ, *supra* note 145, at 4–6.

159. *See* Dustin D. Berger, *The Management of Health Care Costs: Independent Medical Review after "Obamacare"*, 42 U. MEM. L. REV. 255, 274 (2011).

160. *See* CHRISTINE EIBNER ET AL., EMPLOYER SELF-INSURANCE DECISIONS AND THE IMPLICATIONS OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT AS MODIFIED BY THE HEALTH CARE AND EDUCATION RECONCILIATION ACT OF 2010 (ACA) 32 (2011).

161. *See id.* at 29.

162. *See id.*

raw numbers reveal little about the effect of disputes over medical necessity, as they gather denials of many sorts, including those based on documentation errors, patient ineligibility for coverage, failure to obtain pre-authorization, and medical necessity disputes.[163]

Attempts to tease out the rates of medical necessity denials and appeals have been few. Professors Hall and Anderson in 1992 relied on a 1989 IOM report to estimate the rate of medical necessity denials at "one to two percent."[164] Researchers from the RAND Corporation subsequently provided more detailed information about denial rates through interviews of plan decision-makers and review of administrative documents.[165] The researchers found that these sources reported overall denial rates of six percent for prospective coverage requests and twenty-three percent for retrospective requests.[166] The researchers also found that very few of the retrospective denials were on medical necessity grounds, while twenty-nine percent of the prospective denials were on the ground that the care was not medically necessary.[167]

Using a different, larger data set, RAND Corporation researchers also were able to review what happened next: what were the results of appeals from those denials of coverage?[168] These researchers had access to the internal appeals records kept by two California HMOs, with combined enrollment of "several million commercial HMO enrollees."[169] The HMOs had slightly different internal appeals processes. One had a two-step, and the other a three-step internal appeals process.[170] The rates of appeal "were virtually identical at the two plans, with approximately 3.5 [appeals] per thousand enrollees per year."[171] Approximately 70 percent of the appeals from one of the plans were from prospective denials.[172] Forty-nine percent of those prospective denials were medical necessity denials, for a rate of approximately 1.2 appeals from medical necessity denials per thousand enrollees per year.[173] The internal appeals

163. *Id.* at 32–33.

164. Hall & Henderson, *supra* note 120, at 1654.

165. *See* Kanika Kapur et al., *Managing Care: Utilization Review In Action At Two Capitated Medical Groups*, HEALTH AFF. (WEB EXCLUSIVE), June 2003, at W3-275, W3-276, http://content.healthaffairs.org/content/early/2003/06/18/hlthaff.w3.275.full.pdf+html; Gresenz et al., *supra* note 141, at 190.

166. Kapur et al., *supra* note 165, at W3-279.

167. *Id.*

168. Gresenz et al., *supra* note 141, at 190.

169. *Id.*

170. *Id.* at 191.

171. *Id.*

172. *Id.*

173. Gresenz et al., *supra* note 141, at 191, 193.

process favored the enrollee and resulted in a reversal of the original denial in 70.3 percent of cases.[174]

C. *The Significance and Instrumental Use of Medical Necessity Review*

Consumers and health care providers often feel that medical necessity denials represent the imposition of non-clinical decision-makers into what should be a therapeutic setting.[175] The truth is more complicated. Most or all final decisions denying coverage on medical necessity grounds are made by health care professionals with credentials appropriate to the task.[176] Review of medical claims by insurers serves valuable functions. If a requested treatment is indeed not "medically necessary," its provision is at least a waste of scarce funds and at worst a threat to the health of the insured.[177] But given the inescapable indeterminacy of the term "medical necessity," leaving the review of claims for medical necessity exclusively to health plans leaves open the possibility of mistake or abuse.[178]

Medical necessity disputes can reveal situations directly applying this balance between prudent administration of health plans and assurance that the plans deliver on their obligations to connect their insureds with medically appropriate care. The somewhat scant data available on appeals suggest that further investigation may be helpful in several ways.

First, public dissemination of analysis of medical necessity review can address a perception that plan decision-making and review is inconsistent and unprincipled. Reviewing and analyzing denials and appeals processes can provide a "common law" of medical necessity, providing a basis for judging plan decision-making.[179] Enhancing and reinforcing legitimacy in this process is critically important to the success of the ACA. Such legitimacy is proof against both inadvertent error that can harm insureds medically and invidious manipulation of the medical necessity judgment that can be harmful at a deeper level. As Professor Daniel Skinner has observed:

> [M]edical necessity constitutes a more case- or condition- specific concept than benefits, a difference that suggests a key challenge for ACA implementation concerning medical necessity decision-making:

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174. *Id.* at 192.

175. *See* Nan D. Hunter, Managed Process, Due Care: Structures of Accountability in Health Care, 6 YALE J. HEALTH POL'Y, L. & ETHICS 93, 99 (2006).

176. *See* Singer & Bergthold, *supra* note 130, at 201.

177. *See* Sage, *supra* note 9, at 605–06.

178. *See* Bergthold, *supra* note 125, at 185–86.

179. *See* Gresenz et al., *supra* note 141, at 194.

how to ensure that the ACA's antidiscrimination protections for benefits are extended to the level of the more variable concept of medical necessity. "Flexibility," in other words, poses a potential problem when it leads to unfair or inconsistent practices in determining medical necessity.[180]

Second, a consistent and publicly reported process serves a sentinel effect. As the somewhat scant literature described above suggests, medical denials and the results of internal appeals by plans vary quite a bit, without obvious explanation.[181] Examination of the insureds' experience in medical necessity situations–both on initial denial and on review–could provide valuable information about the friction points in coverage and suggest means for improving understanding of health plans' decision-making in the reformed marketplace. This review could discover which plans are interpreting common clinical evidence more or less stringently, and a broader analysis could disclose the relative validity of differing interpretations. This information could be of use to regulators directly, as they assess the market behavior of plans, and, in addition, the information could help inform consumers as they choose health plans.

Finally, attention to medical necessity decision and appeals processes can help to understand the extent to which medical necessity determinations are harming patients. The data on the rate of medical necessity denials is sketchy, as has been described.[182] If the inconvenience of pursuing appeals or other inhibitions stifle the expression of dissatisfaction, then the magnitude of the problem could be greater than previously described. Examining the scope of the problem could be helpful to regulators. If the true number of disputes is relatively small, then the regulatory process likely is working well and may require little adjustment. If it appears that the number of medical necessity disputes is relatively large, then more regulatory attention may be called for. Better information can permit an inquiry into the "epidemiology" of the medical necessity question, permitting examination of who appeals, who does not, and why.[183]

IV. RESTRICTED PROVIDER NETWORKS

Without an adequate supply of qualified and available health care providers, consumers cannot access appropriate care. Most health plans

180. *See* Daniel Skinner, *Defining Medical Necessity under the Patient Protection and Affordable Care Act,* 73 PUB. ADMIN. R. 49, 51 (2013); *see* Part V, *infra*.

181. *See* Singer & Bergthold, *supra* note 130, at 201.

182. *See* EIBNER ET AL., *supra* note 160, at 32–33.

183. *See* Gresenz et al., *supra* note 141, at 194.

today maintain a network of health care providers and either limit their members to in-network providers or require substantial out-of-pocket payments for access to out-of-network providers.[184] In recent years, the breadth of these networks has waxed and waned. In the 1980s and early 1990s, narrow provider-network HMOs competed with broader plans.[185] After a consumer backlash against perceived restrictions on access to care, HMOs turned away from narrow network models.[186] At the same time, non-HMO insurers were creating networks of their own, blurring the lines between HMOs and other forms of coverage.[187] On one hand, few plans maintained narrow networks. On the other hand, most plans did maintain a defined panel of in-network providers, which the insureds were either limited to or strongly incented to use.[188]

Narrow networks[189] offer several benefits. Narrowing networks gives plans the ability to bargain to pay providers less, because the narrower a plan's network is, the more of the plan's enrollees a participating provider can expect to serve.[190] Plans can then pass on their savings from paying providers less to enrollees in the form of lower premiums.[191] In addition, selective contracting can allow insurers to include providers with a proven record of high-quality care and to favor providers able to shift to new models of patient-centered care

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184. *See How to Choose Marketplace Insurance: How to Keep Your Doctor*, HEALTHCARE.GOV, https://www.healthcare.gov/choose-a-plan/keep-your-doctor/ (last visited Aug. 9, 2015); AHIP FOUNDATION, A CONSUMER GUIDE TO UNDERSTANDING HEALTH PLAN NETWORKS 12 (2014), http://www.ahipfoundation.org/Interactive-Consumer-Guide.pdf; *see also* NOAM BAUMAN ET AL., MCKINSEY CTR. FOR U.S. HEALTH SYSTEM REFORM, HOSPITAL NETWORKS: EVOLUTION OF THE CONFIGURATIONS ON THE 2015 EXCHANGES (Apr. 2015), http://healthcare.mckinsey.com/sites/default/files/2015HospitalNetworks.pdf.

185. *See* SABRINA CORLETTE ET AL., CTR. ON HEALTH INS. REFORMS, GEORGETOWN UNIV., NARROW PROVIDER NETWORKS IN NEW HEATH PLANS: BALANCING AFFORDABILITY WITH ACCESS TO QUALITY CARE 2 (May 29, 2014).

186. *See id.*; Marc A. Rodwin, *The Metamorphosis of Managed Care: Implications for Health Reform Internationally,* 38 J. LAW, MED., & ETHICS 352, 353 (2010).

187. *See* CORLETTE ET AL., *supra* note 185, at 6; Rodwin, *supra* note 186, at 357–58.

188. *See* CORLETTE ET AL., supra note 185, at 2; Rodwin, *supra* note 186, at 357–58.

189. For these purposes, the term "narrow networks" is intended to include plans that limit coverage to a discrete, selective group of providers, and plans that "tier" their providers, covering selected providers with low cost-share for insureds, and other providers at increased cost-share for insureds. *See* James C. Robinson, *Hospital Tiers In Health Insurance: Balancing Consumer Choice With Financial Motives,* HEALTH AFF. (WEB EXCLUSIVE), Mar. 2003 at w3-35, W3-36, http://content.healthaffairs.org/content/early/ 2003/03/19/hlthaff.w3.135.citation

190. *See* James C. Robinson, *Reinvention of Health Insurance in the Consumer Era,* 291 JAMA 1880, 1882 (2004).

191. *See id.* Note that the increasing concentration of providers in consolidated business models weakens insurers' bargaining position. *See* CORLETTE ET AL., *supra* note185, at 3.

management, which is particularly important for high-needs insureds with chronic illnesses.[192]

Narrow networks and tiered networks also can present risks. First, narrow networks may impose significant financial hardship due to unavailability of care.[193] Care might be unavailable if in-network providers are not geographically proximate to the insured, are not taking appointments within a medically reasonable time, or if no network provider is qualified to provide particular medically-necessary care.[194] Resort to out-of-network or higher-tier providers may leave the insured responsible for paying substantial out-of-pocket costs.[195] As HHS has explained, "balance billing amounts for non-network providers and other out-of-network cost-sharing" will not count toward the insured's out-of-pocket maximum.[196] Second, the unavailability of in-network providers may lead to health degradation if the insured does not have the resources to pay for out-of-network care.[197]

Issues of network adequacy have reemerged with the implementation of the ACA. As plans attempt to meet ACA requirements while restraining premiums, many have offered products with narrow provider networks[198] and tiered networks.[199] The costs and

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192. *See* Sabrina Corlette, *State Insurance Exchanges Face Challenges In Offering Standardized Choices Alongside Innovative Value-Based Insurance,* 32 HEALTH AFF., Feb. 2013, at 418, 419; James C. Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*, 29 HEALTH AFF., Nov. 2014, at 2009, 2010.

[hereinafter Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*].

193. *See* Tracy Jan, *UnitedHealthcare to cut doctors for Mass. Seniors*, BOSTON GLOBE (June 7, 2014); Ricardo Alonso-Zaldivar, *Concerns about Cancer Centers under Health Law,* SAN DIEGO UNION-TRIB. (Mar. 18, 2014), http://www.utsandiego.com/news/2014/Mar/18/concerns-about-cancer-centers-under-health-law/.

194. *Id.*

195. *See* Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*, *supra* note 192, at 2010.

196. *See Out-of-pocket Maximum Limit*, HEALTHCARE.GOV, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/ (last visited Aug. 4, 2014).

197. *See* Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*, *supra* note 192, at 2010.

198. *See* MCKINSEY CTR. FOR U.S. HEALTH SYSTEM REFORM, HOSPITAL NETWORKS: UPDATED NATIONAL VIEW OF CONFIGURATIONS ON THE EXCHANGES 1 (June 2014),

[hereinafter MCKINSEY CTR., UPDATED NATIONAL VIEW].

199. As Paul Ginsburg has described, plans using "tiered networks":

> sort network providers into tiers according to the insurer's assessment of costs and quality and then vary the deductible or other elements of patients' cost sharing by tier. This approach could potentially shift care to less costly providers and induce the more costly ones to become more efficient.

Paul B. Ginsburg, *Reforming Provider Payment – The Price Side of the Equation,* 365 NEW ENG. J. MED. 1268, 1268–69 (2001).

benefits of these plan designs will require thoughtful regulatory responses.

A. *Regulating Network Adequacy*

Regulators have experimented with consumer protection measures to mitigate the potential risks of narrow or tiered networks. Before the passage of the ACA in 2010, the federal government did not regulate the network adequacy of individual and small-group plans,[200] deferring instead to the states as the primary regulators of private health insurance.[201] Prior to the ACA, nearly all states had adopted network adequacy standards for HMOs and approximately half of the states had standards for preferred provider organizations ("PPOs").[202] Most states employ broad, subjective standards, such as requiring "reasonable access" to providers."[203] Some states have opted for quantitative standards, including establishing provider-to-enrollee ratios and maximum travel times, travel distances, and appointment wait times, as well as requiring a minimum number of providers who are accepting new patients and who are available in a given service area.[204] A handful of states, such as California and Connecticut, include standards regarding access to essential community providers, who serve low-income and medically underserved individuals.[205] The National Association of Insurance Commissioners ("NAIC") also developed a model law, the Managed Care Plan Network Adequacy Model Act #74, which recommends that state regulation address:

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200. The federal government does regulate network adequacy in public programs, including Medicare Advantage and Medicaid Managed Care plans. *See* Quynh Chi Nguyen, *Network Adequacy: What Advocates Need to Know*, COMMUNITY CATALYST, 3 (Jan. 2014), http://www.communitycatalyst.org/resources/publications/document/Network-Adequacy_what-advocates-need-to-know_FINAL-01-28-14.pdf; Jean A. Talbot et al., *Rural Considerations in Establishing Network Adequacy Standards for Qualified Health Plans in State and Regional Health Insurance Exchanges*, 29 J. OF RURAL HEALTH 327, 329–30 (2013).

201. HEALTH MGMT. ASSOCS., ENSURING CONSUMERS' ACCESS TO CARE: NETWORK ADEQUACY STATE INSURANCE SURVEY FINDINGS AND RECOMMENDATIONS FOR REGULATORY REFORMS IN A CHANGING INSURANCE MARKET 5 (Nov. 2014), http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf.

202. *See* MCKINSEY CTR., UPDATED NATIONAL VIEW, *supra* note 198, at 1.

203. *See* LAURA SPICER ET AL., MD. HEALTH BENEFIT EXCHANGE (MHBE) STANDING ADVISORY COMM., HILLTOP INST., NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDERS 13–14, (Jul. 9, 2014); *see also* Nguyen, *supra* note 200, at 2 ("Most states have broad standards requiring health plans in the private insurance market to have a 'robust' or 'sufficient' market.").

204. *See* SPICER ET AL., *supra* note 203, at 13–14.

205. *Id.* at 3, 17.

> maximum number of enrollees per primary care and specialty providers[;]
>
> geographic accessibility[;]
>
> waiting times for appointments with participating providers[;]
>
> hours of operation[; and]
>
> volume of technological and specialty services available to serve the needs of covered persons requiring advanced technology or specialty care[.][206]

The ACA, for the first time, created federal oversight of network adequacy, although only for QHPs. The ACA opts for a broad standard and left the states with considerable flexibility to determine how to regulate QHP networks.[207] The ACA requires the Secretary of HHS to promulgate regulations establishing standards for the certification of health plans as QHPs that would, among other things, "ensure sufficient choice of providers . . . and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers[.]"[208] The statute also requires plans to include Essential Community Providers ("ECPs") within plan networks, where available, "that serve predominately low-income, medically-underserved individuals."[209]

For a health plan to be certified as a QHP and thus be eligible to be sold on the exchanges, the regulations implementing the ACA's statutory commands require issuers to "[m]aintain[] a network that is sufficient in number and types of providers, including [those] that specialize in mental health and substance abuse services, to assure that all services will be available without unreasonable delay."[210]

Issuers also must ensure that the network for each of their QHPs includes "a sufficient number and geographic distribution of essential community providers [ECPs], where available, to ensure reasonable and timely access to a broad range of such providers."[211] Through guidance

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206. Nguyen, *supra* note 200, at 2; *see also* NAT'L ASSOC'N OF INS. COMM'RS, MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT #74 (Oct. 1996); SALLY MCCARTY & MAX FARRIS, STATE HEALTH REFORM ASSISTANCE NETWORK, ACA IMPLICATIONS FOR STATE NETWORK ADEQUACY STANDARDS (Aug. 2013) (comparing network adequacy requirements set forth in the NAIC Network Adequacy Model Act, the ACA and its implementing regulations and guidance, and ten states' laws).

207. HEALTH MGMT. ASSOCS., *supra* note 201, at 10.

208. 42 U.S.C. § 18031(c)(1)(B) (2012).

209. *Id.* § 18031(c)(1)(C).

210. 45 C.F.R. § 156.230(a)(2) (2014).

211. *Id.* § 156.235(a)(1); *see also id.* § 156.230(a)(1). The ACA's implementing regulations also provide an alternate ECP standard for "[a] QHP issuer that provides a

issued in 2013, CMS created a safe harbor for QHP applications that demonstrated the participation of at least 20 percent of available ECPs in the service area, all available Indian providers in the service area, and at least one ECP in each ECP category in each county in the service area, where available.[212] QHP applicants that did not meet the safe harbor, but had at least ten percent of available ECPs in the plan service area, could submit a narrative justification describing how their networks provided an adequate level of service for low-income and medically underserved consumers.[213] Applicants who satisfied neither the safe harbor nor the ten percent minimum expectation could submit a narrative justification describing how their current network would provide access and how they planned to increase ECP participation in the future.[214]

In addition, QHP issuers must provide the exchange with their network provider directory to be published online and provide hard copies of directories to potential enrollees when requested.[215] The provider directory must indicate if a provider is not accepting new patients.[216] Through guidance, CMS indicated to issuers that it expects directories "to include location, contact information, specialty and medical group, and any institutional affiliations for each provider," and encouraged issuers to include information such as "languages spoken, provider credentials, and whether the provider is an Indian provider."[217] The agency, however, did not initially issue guidance regarding how frequently directories need to be updated.[218]

Neither the federal statute nor regulations define key terms, like "unreasonable delay," instead "leaving the implementation of specific standards either to insurers or to the states."[219] For the 2014 plan year, "[i]n states with sufficient network adequacy reviews," CMS relied on state analyses and recommendations concerning network adequacy as

majority of covered professional services through physicians employed by the issuer or through a single contracted medical group." *Id.* §§ 156.235(a)(2), (b).

212. CMS, *2013 Letter to Issuers*, *supra* note 69, at 7.

213. *See id.*

214. *Id.* at 7–8.

215. 45 C.F.R. § 156.230(b).

216. *Id.*

217. CMS, *2013 Letter to Issuers*, *supra* note 69, at 46. Interestingly, despite the regulatory requirement that issuers indicate in directories that providers are not taking new patients, *see* 45 C.F.R. § 156.230(b), the regulatory guidance only encouraged issuers to do so; *see* CMS, *2013 Letter to Issuers*, *supra* note 69, at 46.

218. *See* MCCARTY & FARRIS, *supra* note 206, at 2.

219. Nguyen, *supra* note 200, at 1; *see also* Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310, 18,419 (Mar. 27, 2012).

part of the federal QHP certification evaluation process.[220] CMS also indicated that it would monitor network adequacy by, for example, tracking complaints and gathering data from QHP issuers.[221]

B. Post-ACA Network Adequacy Experiences

Strategies insurers are using to keep premiums in check while complying with the ACA's coverage and rating requirements frequently include reconfiguring, narrowing, and tiering their networks.[222] According to a survey of hospital networks available on the exchanges in 2014, 92 percent of all people eligible to buy QHPs on the exchanges nationally could have chosen a plan with a narrow network of participating hospitals.[223] In 2014, narrow hospital networks comprised 48 percent of all exchange plan networks in the United States and 60 percent of exchange plan networks available in the largest city in each state.[224] A recent follow-up study that analyzed hospital networks available on the exchanges in 2015 similarly found, among other things, that "the proportion of narrowed networks and their relative narrowness has not changed."[225] Narrowed or tiered plans generally offered consumers a lower premium in exchange for a smaller network of hospitals or providers than consumers would find in traditional networks.[226] By limiting the doctors or hospitals available to patients, insurers hope to keep costs down.

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220. CMS, *2013 Letter to Issuers*, *supra* note 69, at 6. CMS relied on issuer accreditation in states that lacked sufficient network adequacy reviews. *See id.*

221. *See id.*

222. *See* David Blumenthal, M.D., M.P.P. & Sara R. Collins, Ph.D., *Health Coverage under the Affordable Care Act – A Progress Report*, 371 N. ENG. J. MED. 275, 278 (2014); Harold Brubaker, *Blue Cross offers guides to health-care 'tiers'*, PHILA. INQUIRER (Oct. 7, 2013), http://articles.philly.com/2013-10-07/business/42766201_1_ibc-insurance-exchange-amerihealth-new-jersey; David Cusano & Amy Thomas, *Narrow Networks Under the ACA: Financial Drivers And Implementation Strategies*, HEALTH AFFAIRS BLOG (Feb. 17, 2014), http://healthaffairs.org/blog/2014/02/17/narrow-networks-under-the-aca-financial-drivers-and-implementation-strategies/.

223. *See* MCKINSEY CTR., UPDATED NATIONAL View, *supra* note 198, at 2, n.6.

224. *Id.* at 2.

225. *See* BAUMAN ET AL., *supra* note 184, at 1.

226. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, GAINING GROUND: AMERICA'S HEALTH INSURANCE COVERAGE AND ACCESS TO CARE AFTER THE AFFORDABLE CARE ACT'S FIRST OPEN ENROLLMENT PERIOD 15 (July 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf; *see also* BAUMAN ET AL., *supra* note 184, at 1 (finding that in 2015, "[m]edian premiums continue to be lower for narrowed-network plans than for broad-network plans").

Early news reports often criticized these narrow networks for restricting patient access to needed medical care.[227] A survey by the Associated Press found that the nation's best cancer centers were not included in the networks for many exchange plans throughout the country.[228] In October 2013, Seattle Children's Hospital in Washington challenged the state insurance commissioner's approval of five of seven exchange plans that did not include the only pediatric hospital in the county within their networks.[229] There also was an outcry when Anthem Blue Cross Blue Shield–the only issuer that applied to sell QHPs in New Hampshire in 2014–left ten of 26 hospitals in the state out of its network.[230]

Consumers also claimed that insurers did not adequately disclose that their plans included narrow or tiered networks. Plaintiffs in California have filed class action lawsuits against Anthem Blue Cross, for example, alleging that the state's largest individual insurance carrier had misled millions of consumers about the scope of its plans' networks of doctors and hospitals.[231] There are also reports that provider directories are not accurate. Consumers in Florida, for example, who purchased exchange plans, have reported that doctors listed in their

227. *See, e.g.*, Carrie Feibel, *Specialty Care Is A Challenge In Some ACA Plans*, KAISER HEALTH NEWS (July 16, 2014); Janet Lavelle, *Finding doctors who take Covered California Plans Isn't Easy, Locals Say*, SAN LUIS OBISPO TRIB. (May 29, 2014), http://www.sanluisobispo.com/2014/05/29/3086450/covered-california-health-insurance.html; Sandhya Somashekhar & Ariana Eunjung Cha, *Insurers Restricting Choice of Doctors and Hospitals to Keep Costs Down*, WASH. POST (Nov. 20, 2013), http://www.washingtonpost.com/national/health-science/insurers-restricting-choice-of-doctors-and-hospitals-to-keep-costs-down/2013/11/20/98c84e20-4bb4-11e3-ac54-aa84301ced81_story.html.

228. *See* Chad Terhune, *Anthem Blue Cross Sued Again Over Narrow-Network Health Plans*, L.A. TIMES (Aug. 19, 2014, 9:38 PM), http://www.latimes.com/business/la-fi-anthem-network-suit-20140820-story.html; Alonso-Zaldivar, *supra* note 194. As the article notes, excluding top cancer centers from networks may also deliver "an implicit message to cancer survivors or people with a strong family history of the disease that they should look elsewhere," *id.*, which raises the specter of risk selection by design. *See infra* Part V(D)(1).

229. *See* Amy Snow Landa, *Left Off Many Networks, Seattle Children's Sues*, SEATTLE TIMES (Oct. 4, 2013), http://seattletimes.com/html/localnews/2021968776_acachildrenssuitxml.html.

230. *See* Sarah Palermo, *Anthem's Narrow Network, N.H. Insurance Regulators Criticized at Hearing*, CONCORD MONITOR (Feb. 11, 2014), http://www.concordmonitor.com/community/town-by-town/concord/10549003-95/anthems-narrow-network-nh-insurance-regulators-criticized-at-hearing.

231. *See* Julie Appleby, *Lawsuit Accuses Anthem Blue Cross Of 'Fraudulent' Enrollment Practices*, KAISER HEALTH NEWS (July 9, 2014), http://www.kaiserhealthnews.org/stories/2014/july/09/anthem-lawsuit-over-enrollment-practices.aspx.

plans' provider directories refused to accept their insurance.[232] The federal marketplace reportedly listed a New Jersey plan as available to residents throughout the state even though it only included one hospital from the southern part of the state in its network.[233]

Several states are acting in response to concerns about network adequacy. According to a July 2014 article in *Politico*, more than 70 bills have been introduced in 22 states seeking to clarify network adequacy requirements, although only a few states have passed legislation to date.[234] As David Cusano of Georgetown University's Center on Health Insurance Reforms has observed, "[m]ost states are aware of the issue but are waiting to [] see how it plays out," seeing if consumers are able to access health care via the narrow networks.[235]

After heavy press coverage of the Seattle Children's Hospital lawsuit, Washington adopted comprehensive revisions to its network adequacy regulations that went into effect in May 2014 for both exchange and off-exchange plans, including much more specific requirements concerning provider accessibility, requirements that carriers grant in-network exceptions, and an obligation on carriers to update their provider directories at least monthly.[236] Following a series of listening sessions, Nevada authorized its insurance commissioner to begin regulating provider networks this year.[237] New York enacted the Emergency Medical Services and Surprise Bills law in June 2014, which, among other things, adopts network adequacy standards for all health insurers, not just HMOs.[238] The law requires that consumers not be

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232. *See* Daniel Chang, *Some South Florida Docs Decline to Accept Obamacare*, MIAMI HERALD (July 12, 2014), http://www.miamiherald.com/news/state/article 1975207.html.

233.*See* Notes from Interview with New Jersey Hospital Association officials (on file with authors).

234. *See* Brett Norman, *Obamacare: Anger Over Narrow Networks*, POLITICO (July 22, 2014), http://www.politico.com/story/2014/07/obamacare-health-care-networks-premiums-109195.html.

235. Sara Hansard, *State Regulators Take 'Wait-and-See' Approach to Narrow Networks*, BLOOMBERG BNA, 22 H.C.P.R. 800 (May 19, 2014) [hereinafter Hansard, *State Regulators*].

236. STATE OF WASH., OFFICE OF THE INS. COMM'R, INSURANCE COMMISSIONER MATTER NO. R 2013-22 (Apr. 25, 2014); Paul Demko, *Reform Update: States debate network adequacy as insurers scramble to submit 2015 products*, MODERN HEALTHCARE (May 1, 2014), http://www.modernhealthcare.com/article/20140501/NEWS/305019964 [hereinafter Demko, *Reform Update*].

237. *See* Demko, *Reform Update*, *supra* note 236.

238. *See* A. 9205, 2014 Gen. Assemb., Reg. Sess. (N.Y. 2014); *see also* Nili S. Yolin, *New York Enacts Out-of-Network Transparency and Coverage Reform,* MINTZ LEVIN (July 8, 2014), http://www.healthlawpolicymatters.com/2014/07/08/new-york-enacts-out-of-network-transparency-and-coverage-reform/.

charged more than their in-network cost-sharing for non-emergency, out-of-network services that they received either because there were no adequate in-network providers or because they were referred to an out-of-network provider without the required disclosures.[239] New Hampshire is considering how it might strengthen its existing network adequacy requirements.[240] A committee of the NAIC has been meeting regularly in 2014 and 2015 to consider proposed revisions to its model state law for network adequacy, the Managed Care Network Adequacy Model Act, which has not been modified since 1996.[241]

The federal government has signaled that it may expand its reach into network adequacy regulation. In its 2015 Letter to Issuers in Federally Facilitated Marketplaces ("FFMs") issued in March 2014 ("2015 Letter to Issuers"), the Center for Consumer Information and Insurance Oversight within HHS' CMS announced that it was altering its QHP certification process with respect to network adequacy review for benefit year 2015.[242] Rather than relying on the accreditation status of the issuer, as it had for plan year 2014, CMS will utilize a "reasonable access" standard to assess provider networks and identify networks that fail to satisfy § 156.230(a)(2)'s requirement of access "without unreasonable delay."[243] To assess "reasonable access," CMS will focus on healthcare areas that "have historically raised network adequacy concerns," which may include hospital systems, mental health providers,

239. *See* A. 9205, 2014 Gen. Assemb., Reg. Sess. (N.Y. 2014); *see also* Yolin, *supra* note 238.

240. *See* Demko, *Reform Update*, *supra* note 236; *see generally* N.H. INS. DEP'T, NETWORK ADEQUACY WORKING GROUP, *Legal Information*, http://www.nh.gov/insurance/legal/nhid_nwadequacy_wg.htm (last visited June 15, 2015).

241. *See id.*; Nat'l Ass'n of Ins. Comm'rs, *Network Adequacy Model Review (B) Subgroup Regulatory Framework (B) Task Force*, http://www.naic.org/committees_b_rftf_namr_sg.htm; NAT'L ASS'N OF INS. COMM'RS, DRAFT PROPOSED REVISIONS TO THE MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT (Nov. 12, 2014), http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_draft_proposed_revisions_mcpna_model_act.pdf; Nguyen, *supra* note 200, at 2; Linda Tiano & M. Brian Hall, IV, *National Association of Insurance Commissioners Releases Draft Model Law Updating Managed Care Adequacy Model Act*, EPSTEIN BECKER GREEN HEALTH CARE & LIFE SCIENCES CLIENT ALERT (Nov. 2014), http://www.ebglaw.com/news/national-association-of-insurance-commissioners-releases-draft-model-law-updating-managed-care-adequacy-model-act/. There have been reports that NAIC also may recommend regulatory revisions rather than a statutory route. *See* Rebecca Adams, *Revisions Weighed to Model Law on Adequacy of Provider Networks*, CQ HEALTHBEAT (Feb. 26, 2014). For a useful comparison of the NAIC's model law and the ACA's network adequacy requirements, *see* NAIC HEALTH INS. & MANAGED CARE (B) COMM., PLAN MGT. FUNCTION: NETWORK ADEQUACY WHITE PAPER, at Appendix C, 17–25 (June 27, 2012), http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf.

242. CMS, *2015 Letter to Issuers*, *supra* note 69, at 18.

243. *Id.*

oncology providers, and primary care providers.[244] Throughout this process, CMS will "share information and analysis and coordinate with states which are conducting network adequacy reviews."[245]

In addition to enforcing the rather general "reasonable access" standard, CMS also indicated in the 2015 Letter to Issuers that it intends to articulate "time and distance or other standards" in a future rulemaking, based on information that it learns from the QHP application process and from the states, signaling that the agency intends to adopt more prescriptive network adequacy regulations in the future.[246] According to news reports in mid-2014, the agency was considering proposing new standards to regulate network adequacy that are similar to those used to regulate Medicare Advantage networks.[247] Medicare Advantage plans measure network adequacy using a variety of criteria that vary by type of specialty providers, health care facility, and county type, including: minimum enrollee-to-provider ratios, maximum travel times and distances to providers, and average number of enrollees within a service area.[248]

HHS recently amended its network adequacy regulations to clarify that a network consists only of in-network providers,[249] which means that "that the general availability of out-of- network providers will not be counted for purposes of meeting network adequacy requirements."[250] It also urged–though it did not require–insurance companies that use networks of providers to provide new enrollees with a period of transitional care for an ongoing course of treatment.[251]

HHS also has provided additional guidance on how it is implementing the ACA's ECP provisions. In its 2015 Letter, CMS

244. *Id.*

245. *Id.*

246. *Id.*

247. Robert Pear, *To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks*, N.Y. TIMES (July 19, 2014), http://www.nytimes.com/2014/07/20/us/insurers-face-new-health-law-rules-to-widen-networks-and-prevent-surprise-bills.html?_r=0.

248. *See* Nguyen, *supra* note 200, at 3; *see generally* Talbot et al., *supra* note 200, at 327-35 (drawing on Medicaid MCO and Medicare Advantage network adequacy regulations in recommending "adjusting standards according to degrees of rurality and rural utilization norms; counting midlevel clinicians toward fulfillment of patient-provider ratios; and allowing plans to ensure rural access through delivery system innovations such as telehealth" as potential strategies to adopt network adequacy requirements "strong enough to provide real protections for beneficiaries, yet flexible enough to accommodate rural delivery system constraints and remain attainable for QHPs").

249. *See* 45 C.F.R. § 156.230(a) (2012).

250. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,830 (Feb. 27, 2015).

251. *See id.*

announced that it was altering the safe harbor that it outlined in its 2013 guidance and now will consider an issuer to be in compliance with the ECP requirements if the issuer's application indicates "that at least 30 percent of available ECPs in each plan's service area participate in the provider network."[252] The Notice of Benefit and Payment Parameters for 2016 Final Rule includes a number of provisions aimed at strengthening the ECP requirements.[253] For example, multiple providers at a single location now count as a single ECP when calculating if the insurance carrier has satisfied the ECP participation standard.[254]

In addition, HHS has provided more specificity regarding the provider directory requirements set forth in the ACA. CMS expects that the required URL link will bring consumers directly to an up-to-date provider directory that is specific to the particular QHP.[255] If issuers offer more than one QHP, it "should be clear to consumers which directory applies to which QHP(s)."[256] Consumers also should not have "to log on, enter a policy number, or otherwise navigate an issuer's website before locating the directory."[257] Additionally, the directory should indicate each provider's "location, contact information, specialty, and medical group, any institutional affiliations, and whether the provider is accepting new patients."[258] CMS also encourages issuers to include "languages spoken, provider credentials, and whether the provider is an Indian health provider."[259]

252. CMS, *2015 Letter to Issuers, supra* note 69, at 19. The 2015 Letter to Issuers provides examples to illustrate the ECP guidelines and demonstrate sample narrative justifications for issuers that do not satisfy the safe harbor. *Id.* at 20–21, 23. It also provides additional information about the ECP guidelines and the QHP application process, including that issuers may suggest providers to be considered as ECPs who are not on CMS's non-exhaustive list of available ECPs and how inclusion of those suggested providers affect the thirty percent calculation. *Id.* at 21–22. The 2015 Letter to Issuers also provides additional guidance for issuers that qualify for the alternate ECP standard in 42 C.F.R. § 156.235(a)(2) and (b). *See supra* note 211; CMS, *2015 Letter to Issuers, supra* note 69, at 23-24.

253. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 Fed. Reg. at 10,833–38 (Feb. 27, 2015).

254. *See id.* at 10,833.

255. *See* CMS, *2015 Letter to Issuers, supra* note 69, at 42.

256. *Id.*

257. *Id.*; *accord* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10832.

258. *See* CMS, *2015 Letter to Issuers, supra* note 69, at 42. As noted *supra* note 217, a federal regulation requires issuers to indicate in directories that providers are not taking new patients. *See* 45 C.F.R. § 156.230(b) (2014).

259. CMS, *2015 Letter to Issuers, supra* note 69, at 46.

HHS formalized much[260] of this guidance by amending its network adequacy regulation in February 2015:

> For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when—
>
> (i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and
>
> (ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.[261]

The agency believes that a provider's tier also should be clearly identified in the directory and on the web site.[262] It also requires plans to update directories at least once per month and encourages more frequent updates whenever possible.[263] HHS further strongly encouraged insurance companies to "honor what is listed in their directories even if

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260. HHS did not adopt all of the commenters' suggestions for data to collect, including:

> hours physician traditionally practices at referenced practices, board certification(s), sub-specialties practiced, language spoken by each provider, interpreter services or communication and language assistance services that are available at the provider's facilities and information about how enrollees can obtain such services, publication date of directory, and a field for providing advance notice that the provider will be leaving the network.

Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10832. The agency did not take a position on each of these. *See id.* Rather it generally urged insurance companies "to continuously evaluate the data they include in their directories and aim to provide all of the information that will help consumers understand their network." *Id.*

261. 45 C.F.R. § 156.230(b)(2). Note that although HHS did not create a special enrollment period related to inaccurate, misleading, changing, or inadequate provider networks, the agency noted that "consumers may be determined eligible for [a] special enrollment period . . . if an issuer substantially violates their contract with the enrollee." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,799.

262. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,830.

263. *See id.* at 10,831–32.

there are errors," and encouraged companies to establish a dedicated email address where consumers could advise the carriers of inaccuracies in or changes to information in the directories.[264]

In addition to reviewing network adequacy as part of the annual QHP certification process, CMS indicated that it will continue to monitor a QHP's network adequacy post-certification to determine if the QHP's network continues to comply with certification criteria, such as through complaint tracking.[265] The agency reportedly is considering how to collect data on provider networks to permit CMS to evaluate network adequacy and consumers to search for providers on Healthcare.gov.[266] HHS recently finalized a regulatory requirement that insurance companies make provider directory "information publicly available on their Web sites in a machine-readable file and format specified by HHS."[267] By doing so, HHS hopes software developers will "create innovative and informative tools to help enrollees better understand the availability of providers in a specific plan," which should improve transparency and consumer decision-making.[268]

Although HHS has taken a number of steps to increase its regulatory oversight of network adequacy since the ACA's enactment, its approach has been measured and deliberate. The agency recently announced in the preamble to its Notice of Benefit and Payment Parameters for 2016 Final Rule that, while it "continues to take great interest in ensuring strong network access," it will wait for the NAIC workgroup to complete its work on revisions to the network adequacy model act "before proposing significant changes to network adequacy policy."[269] As a result, HHS plans to continue to apply the reasonable access standard that it adopted in its 2015 Letter to Issuers.[270]

C. *Next Steps for Network Adequacy Regulation*

Moving forward, federal and state regulators will need to evaluate how to respond to narrowing networks and who should be responding. Some state regulators prefer that the matter be left to the states. Kansas Insurance Commissioner Sandy Praeger, for example, who chairs the NAIC subcommittee that is studying revisions to the network adequacy

264. *Id.* at 10,832.

265. *Id.* at 10,830.

266. *Id.*

267. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,830.

268. *Id.; see also* 45 C.F.R. § 156.230(c) (2014).

269. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,830.

270. *See id.*

model law, has said, "it's important for us at NAIC to make sure that we are providing proper guidance to our states around network adequacy and it stays a state issue."[271] Joel Ario, former Director of the Office of Health Insurance Exchanges at HHS and a former insurance commissioner in Pennsylvania and Oregon, agrees, emphasizing that network adequacy issues vary dramatically from state to state.[272] But as discussed above, consumers and the media have raised substantial concerns regarding the adequacy of current, mostly state-based regulation. As discussed above,[273] the federal government has indicated its intent to regulate more directly in this field, and it remains to be seen how the states and federal government will coordinate network adequacy regulatory roles.

But how narrow is too narrow? Some advocates and academics believe narrow networks threaten the health of consumers. Restricting access to the most-expensive specialists and academic health centers can pose especially challenging obstacles to patients with rare or complex medical issues.[274] Narrowing networks could even threaten the success of coverage expansion. As David Blumenthal and Sara Collins of the Commonwealth Fund have observed, "[i]f the quality is lower as a result of such restrictions or consumers feel they cannot get the care they need, they may stop purchasing new insurance plans, thus defeating a central purpose of the law."[275]

Some academics and regulators, however, highlight the potential virtues of narrow networks. For example, David Blumenthal also has pointed out that narrow networks may give issuers greater leverage to negotiate lower reimbursement.[276] The widespread use of narrow networks reportedly contributed to relatively modest premiums in 2014, which were 16 percent below the Congressional Budget Office's predictions.[277] BlueCross BlueShield of Tennessee, for example, was able to offer consumers a plan with a premium that is less expensive than nearly any other midlevel or silver plan in the country by using a narrow

271. Adams, *supra* note 241.

272. *See* Joyce Frieden, *Regulators Shrug at Docs' Network Concerns*, MEDPAGE TODAY (Aug. 11, 2014), http://www.medpagetoday.com/PracticeManagement/Reimbursement/47164.

273. *See supra* notes 242–270 and accompanying text.

274. David Blumenthal, M.D., *Reflecting on Health Reform – Narrow Networks: Boon or Bane,* THE COMMONWEALTH FUND (Feb. 24, 2014), http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane.

275. *See* Blumenthal & Collins, *supra* note 222, at 5.

276. Blumenthal, *supra* note 274.

277. Blumenthal & Collins, *supra* note 222, at 4; COLLINS ET AL., *supra* note 226, at 15.

network.[278] A similar plan would cost nearby Georgia residents 86 percent more each month.[279] The Tennessee network included only one of the three major hospitals in the region, but that hospital is a well-regarded system with the area's only academic teaching hospital, high-level trauma center, and neo-natal intensive care unit.[280] While not all consumers were happy with the restricted network, they could choose to pay more for alternative plans with broader networks.[281]

Karen Ignagni, chief executive of America's Health Insurance Plans, has represented that consumers "are weighing affordability and breadth of network" and often choosing affordability.[282] As recent surveys of exchange plans' hospital networks in 2014 and 2015 conducted by the consulting firm McKinsey & Company suggest, the increased use of narrow networks has provided consumers with greater choice of network offerings.[283] Eighty-six percent of consumers in 2014 and 90 percent in 2015 had the option to purchase a plan on the exchanges that included a broad network, although broad network plans had premiums that were 13 to 17 percent higher than narrow network plan premiums in 2014 and 15 to 23 percent higher in 2015.[284] Notably, McKinsey found "no meaningful performance difference between broad and narrowed exchange networks" based on four CMS hospital quality metrics.[285] A survey by the Commonwealth Fund found that fifty-one percent of consumers who were given a choice of a network with fewer doctors or hospitals at a lower cost chose the narrow network.[286] Ario believes that the ACA anticipated competition that includes plans with narrow networks among a broad range of choices.[287]

278. *See* Jordan Rau, *In Unhealthy Eastern Tennessee, Limited Patient Options Bring Some Of The Country's Cheapest Premiums*, KAISER HEALTH NEWS (July 8, 2014) http://khn.org/news/in-unhealthy-eastern-tennessee-limited-patient-options-brings-some-of-the-countrys-cheapest-premiums/.

279. *See id.*

280. *See id.*

281. *See id.*

282. Reed Abelson, *More Insured, but the Choices Are Narrowing*, N.Y. TIMES (May 12, 2014), http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html?_r=0.

283. *See* MCKINSEY CTR, UPDATED NATIONAL VIEW, *supra* note 198, at 2,

284. *See id.*

285. *See id.* at 3. Note, however, that academic medical centers had higher rates of participation in broad networks in 2014. *See id.*.

286. COLLINS ET AL., *supra* note 226, at 15.

287. *See* Sara Hansard, *Need for More Young Enrollees on Exchanges Highlighted at Health-Care Outlook Event*, BLOOMBERG BNA HEALTH INS. REPT. (Jan. 22, 2104) http://www.bna.com/need-young-enrollees-n17179881487/. [hereinafter Hansard, *Need for More*].

As is true in the debate over essential health benefits,[288] network adequacy demands that we balance access to care with costs. "'People have to recognize it's a trade-off, and I'm not sure they do yet,' said Matt Eyles, an insurance expert at the Avalere Health consulting firm. 'Broader access comes at a cost, and what's the right balance between access and cost is an age-old question in health care.'"[289]

When it comes to network adequacy, several factors complicate the balance that regulators need to strike between access and cost. First, there is a question of consumer awareness. The 2014 McKinsey survey found that 26 percent of consumers who enrolled in exchange plans did not know whether they had chosen a broad or narrow network plan, and this number jumped to 42 percent for consumers who previously were not insured.[290] Forty percent of consumers surveyed who chose an exchange plan would have liked more information about which providers participated in their plan.[291] In 2015, 44 percent of consumers surveyed who purchased an exchange plan for the first time reported that they did not know how their plan's network was configured.[292] Nineteen percent of those surveyed in 2015 that had bought exchange plans in 2014 still did not know how their plan was configured.[293]

Even when consumers are aware that a plan offers a narrow network, they may not make a choice that rationally weighs all options and factors. Twenty-seven percent of consumers who purchased non-group coverage for 2014 identified cost as the most important factor in choosing a plan, whereas only 11 percent identified choice of doctors or providers as the most important factor.[294] As insurance executive Kathleen Oestreich explained, "[p]rice was the only differentiator" among exchange plans: "Most consumers did not shop product and network as carefully as they probably should have. They were very

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288. *See supra*, Part II.

289. Norman, *supra* note 234.

290. *See* MCKINSEY CTR., UPDATED NATIONAL VIEW, *supra* note 198, at 3, 14.

291. *Id.* at 15.

292. *Id.* at 2

293. *See id.*

294. KAISER FAMILY FOUNDATION, *Topline: Survey of Non-Group Health Insurance Enrollees*, at 19 (June 2014), http://kaiserfamilyfoundation.files.wordpress.com/2014/06/8306-t2.pdf [hereinafter KAISER FAMILY FOUNDATION, *Topline*]. *Cf.* Russell Korobkin, *The Efficiency of Managed Care "Patient Protection" Laws: Incomplete Contracts, Bounded Rationality, and Market Failure*, 85 CORNELL L. REV. 1, 8–9 (Nov. 1999) ("Relying on empirical evidence that consumers have cognitive limitations that cause them to make decisions in only a 'boundedly rational' manner, Part III examines the ways in which even informed consumers are likely to fail to make individual health insurance purchasing decisions in a way that promotes efficiency.").

much focused on buying the cheapest plans, period."[295] Even if a consumer considers provider access and not just price, however, consumers cannot always know what types of providers they will need in the coming year, so there are natural limits on how rational their choices can be.[296]

As a result, some urge that including quality metrics in network descriptions will assist consumer choice and minimize the risk that consumers will evaluate network options based on price alone. Community Catalyst, for example, recommends that, in addition to "travel times, distances, and appointment waiting times," states consider "quality of care and affordability, including enrollees' out-of-network cost-sharing" when evaluating the network adequacy of plans.[297] Quality metrics can be a valuable tool to evaluate whether "less-costly providers have comparable or better quality" than more costly providers.[298] Joel Ario, for example, has asserted that "[n]arrow or 'select' or 'tiered' networks can be [an] integral part of quality improvement strategies as well as a cost-saving strategy," noting that many of the networks that perform well on quality are integrated delivery systems like Kaiser.[299]

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295. Joanne Sammer, *ACA Exchanges: Price still king*, MANAGED HEALTHCARE EXEC. (May 30, 2014), http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/aca-exchanges-price-still-king?page=full.

296. *See, e.g.*, Judy Sarasohn, U.S. DEP'T OF HEALTH & HUMAN SERVCS., *I'm Covered Stories: A Just-in-Time Convert to Health Insurance*, http://www.hhs.gov/healthcare/facts/blog/2014/07/im-covered-stories-robert-mandler-jr.html (last visited Jul. 30, 2014) (sharing the story of a consumer who was glad he enrolled in a health insurance plan because he subsequently learned he had a late-stage cancer); *see generally* Korobkin, *supra* note 294, at 28 (noting that a consumer "most likely could not learn whether, given a particular contingency, an [insurer] would provide her with a specific treatment benefit until she experienced that condition while under the [insurer's plan]").

297. Nguyen, *supra* note 200, at 4; Andrew Bindman, *JAMA Forum: Much Ado About Narrow Networks* (Aug. 13, 2014) http://newsatjama.jama.com/2014/08/13/jama-forum-much-ado-about-narrow-networks/ (encouraging transparency regarding costs, quality, and other factors used in establishing networks and the inclusion of out-of-pocket costs incurred by consumers subject to narrow networks in actuarial value calculations).

298. BLUMENTHAL, *supra* note 274; *see also* Timothy Layton, *If plans are only offering narrow networks, blame information asymmetry*, THE INCIDENTAL ECONOMIST BLOG (May 29, 2014 1:15 PM) http://theincidentaleconomist.com/wordpress/if-plans-are-only-offering-narrow-networks-blame-information-asymmetry/ (suggesting that assigning plans "network quality tiers" in addition to metal levels may correct information asymmetry that is contributing to market failure); *see generally* Mary Agnes Carey, *More Employers Limit Health Plan Networks But Seek to Preserve Quality, Says Adviser*, KAISER HEALTH NEWS (Aug. 13, 2014) http://www.kaiserhealthnews.org/Stories/2014/August/13/More-Employers-Limit-Health-Plan-Networks-But-Seek-To-Preserve-Quality.aspx (reporting that according to Dr. Robert Galvin, chief executive officer of Equity Healthcare, "performance networks" that are based on performance and not just costs "are definitely increasing in popularity").

299. Joel Ario, MANATT HEALTH SOLUTIONS, *The Emerging Exchange Marketplace*, at 19 (Nov. 19, 2014), https://www.statereforum.org/sites/default/files/manatt_webinar_-

Further, accountable care organizations ("ACOs"), which build quality measures into their design, "with significant scale in a local market can become narrow network products."[300] Consumers need more information to help them distinguish high-quality narrow networks from the rest.

To find the right balance between access and cost, it also is vital to assess the level of access problems that are attributable to narrow networks. As chronicled above, early news reports cited the lack of consumer access, and attributed these problems to narrow networks.[301] Yet a recent survey by the Commonwealth Fund reports more encouraging numbers:

> Four of five people with new marketplace or Medicaid coverage are optimistic that it will improve their ability to get the care they need. More than half said they are better off now than they were before enrolling in their new insurance.
>
> By June 2014, six of ten adults with new marketplace or Medicaid coverage said they had used their insurance to go to a doctor or hospital or to fill a prescription. A majority said they would not have been able to access or afford this care before enrolling.
>
> More than half of adults with new coverage said their plan included all or some of the doctors they wanted.
>
> One of five adults with new coverage tried to find a new primary care physician; three-quarters found it very or somewhat easy to do so.[302]

_the_emerging_exchange_marketplace.pdf; *see also* Sarah Kliff, *Obamacare's narrow networks are going to make people furious – but they might control costs*, WASH. POST WONKBLOG (updated Jan. 13, 2014 1:30 PM) http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/13/obamacares-narrow-networks-are-going-to-make-people-furious-but-they-might-control-costs/.

300. Ario, *supra* note 299, at 26; *see generally* Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans Proposed Rule, 76 Fed. Reg. 41,866, 41,899 (July 15, 2011) (explaining that HHS decided not to propose mandatory contracting requirements with ECPs because "such a requirement may inhibit attempts to use network design to incentivize higher quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals"), http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf; *see, e.g.*, Thomas Bartrum, Esq. & Deborah Farringer, Esq., BAKER DONELSON, *The Rise of Narrow Networks: Opportunities, Risks & Legal Uncertainties* 5, http://www.bakerdonelson.com/files/Uploads/Documents/BartrumNashvilleCouncil.pdf (last visited July 30, 2014) (noting that clinically integrated networks and accountable care organizations "can serve as the basis for either a narrow network or a tiered network product").

301. *See supra* notes 227–233 and accompanying text.

302. COLLINS ET AL., *supra* note 226, at 2.

Similarly, in a Kaiser Family Foundation poll of non-group health insurance enrollees, 45 percent of respondents were very satisfied and 36 percent were somewhat satisfied with their choice of primary care doctors available under their plan.[303] Forty-three percent were very satisfied; 37 percent were somewhat satisfied with their choice of hospitals and 35 percent were very satisfied; and another 35 percent were somewhat satisfied with their choice of specialists.[304] Fifty-six percent believed that their current plan offered about the same choice of primary care doctors, 13 percent thought it offered more choice, and 27 percent thought it offered less choice than their pre-ACA coverage.[305]

Without dismissing concerns over access to particular providers, Joel Ario cautions against overreacting to narrow networks because "[t]he market really does need some room to innovate here."[306] Although there should be standards to facilitate transparency and network adequacy, Ario urges that "there has to be a market to experiment with tiered networks, narrow networks and different types of networks. It's important that we don't get network adequacy standards that basically restrict competition."[307] Regulators should also consider whether to adapt network adequacy requirements to reflect delivery system and technological innovations, including value-based purchasing, care coordination, physician-extenders, care coordinators, and telemedicine.[308]

Joel Ario has acknowledged that one area for potential regulatory inquiry is over whether insurers are adequately disclosing their plans' narrow networks.[309] Reportedly, "regulators, consumer advocates and insurers all agree that the information about what doctors are in a plan's network needs to be more available, up-to-date and consumer-friendly."[310] Indeed, David Cusano has suggested that, if regulators act early to improve transparency surrounding QHP provider networks,

303. KAISER FAMILY FOUNDATION, *Topline*, *supra* note 294, at 8.

304. *Id.* at 9.

305. *Id.* at 23.

306. Paul Demko, *Flurry of new ACA rules adds to insurers' uncertainty*, MODERN HEALTHCARE (Mar. 17, 2014) http://www.modernhealthcare.com/article/20140317/NEWS/303179949.

307. *Quote of the Day*, AIS'S HEALTH BUSINESS DAILY (Apr. 3, 2014), http://aishealth.com/enews/businessnews/2014-04-03 (quoting Joel Ario in a gated article).

308. *See, e.g.*, NATIONAL COMMITTEE FOR QUALITY ASSURANCE, NETWORK ADEQUACY & EXCHANGES: HOW DELIVERY SYSTEM REFORM AND TECHNOLOGY MAY CHANGE HOW WE EVALUATE HEALTH PLAN PROVIDER NETWORKS, at 1–2 (2013), http://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf.

309. Hansard, *Need for More*, *supra* note 287.

310. Norman, *supra* note 234; *see also* CORLETTE ET AL.,*supra* note185, at 1, 9.

"[t]hat might mitigate the need for more prescriptive network adequacy standards going forward."[311] The National Health Council has suggested "that exchange websites contain a searchable formulary tool–similar to the Medicare Part D plan finder–that facilitates comparison of QHPs by drug coverage and cost-sharing."[312] A similar tool that would enable easy comparison of QHPs by provider network also would be a helpful addition to exchange websites. HHS's Notice of Benefit and Payment Parameters for 2016 Final Rule requires insurance companies to file network adequacy and formulary information in machine-readable formats,[313] which should facilitate development of tools to help consumers compare plans.

There are calls for state and federal regulators to increase their efforts to monitor plan networks and whether consumers are accessing care in-network or out-of-network.[314] The NAIC, for example, has recommended that regulators conduct an in-depth review of network adequacy when the network initially is approved and then at least annually.[315] It also recommends requiring carriers to notify the state "at least quarterly of general changes in their network, as well as requiring prompt notice of a potential loss of a material provider, such as a hospital or a multi-specialty clinic."[316] But in practice, many states "do little to assess their network adequacy. To the extent state regulators provide oversight, it is most commonly in response to consumer complaints."[317]

To facilitate ongoing monitoring of plan compliance with network adequacy requirements and assessment of the efficacy of existing regulatory requirements, it is important to collect and distribute data about consumer access. As Quynh Chi Nguyen of Community Catalyst has noted,[318] the ACA requires carriers to report cost-sharing and payments for out-of-network coverage to HHS and state regulators and to make this information available to the public.[319] This information should

311. Hansard, *State Regulators*, *supra* note 235; *see also* Layton, *supra* note 298.

312. Letter from National Health Council to Secretary Sebelius Re: Urgent Need for Increased Network Adequacy Standards and Patient Protections against Discriminatory Plan Designs, at 3 (Feb. 25, 2015), http://www.nationalhealthcouncil.org/NHC_Files/Pdf_Files/NHCComments-Draft2015IssuerLetter.pdf.

313. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 Fed. Reg. 10,750, 10,819, 10,820, 10,830, 10832–33 (Feb. 27, 2015), http://www.gpo.gov/fdsys/pkg/FR-2015-02-27/pdf/2015-03751.pdf.

314. *See* CORLETTE ET AL., *supra* note185, at 1.

315. *See* NAIC HEALTH INS. & MANAGED CARE (B) COMM., *supra* note 241, at 5.

316. *Id.*

317. Nguyen, *supra* note 200, at 2.

318. *See id.* at 5.

319. *See* 42 U.S.C. §§ 18031(e)(3)(A), 300gg-15a (2012).

offer valuable insights into the network adequacy of plans that should help regulators strike the right balance "among cost, quality, access, and choice."[320]

V. DISCRIMINATION IN HEALTH INSURANCE PLAN DESIGN AND ADMINISTRATION

A final way that individuals may be denied access to the essential health benefits to which they are entitled is through plan designs that unfairly discriminate, whether intentionally or not, as well as through unfairly discriminatory plan administration.[321] Coverage exclusions and provider networks are examples of aspects of an insurance plan's design with the potential to be discriminatory.[322] Aspects of plan administration that can be discriminatory include eligibility determinations, coverage interpretations, medical necessity decisions, and rescissions of coverage.[323]

Discrimination in insurance can be based on criteria such as age, gender, national origin, race, or religion, as well as health status. Before the passage of the ACA, it was standard practice in many states for

320. Cusano & Thomas, *supra* note 222; *see also* CORLETTE ET AL., *supra* note185, at 1 (concluding "that an appropriate balance between consumer choice and cost containment can be struck with a mix of strategies that include regulatory standards, better consumer information and more robust oversight").

321. Jessica Roberts has defined discrimination as "systematic disadvantage related to a protected trait or status." Jessica L. Roberts, *"Healthism": A Critique of the Antidiscrimination Approach to Health Insurance and Health-Care Reform*, 2012 U. ILL. L. REV. 1159, 1172–74 (2012) (explaining that the dictionary definition of "discriminate" is simply to differentiate, and noting that "what makes one kind of differentiation acceptable and another morally reprehensible—and perhaps legally actionable—is a complicated question and one that relies heavily on historical and cultural context").

322. *See* Parts II & IV, *supra* (discussing explicit exclusions from coverage and network adequacy respectively); *see also* KATIE KEITH ET AL., NONDISCRIMINATION UNDER THE AFFORDABLE CARE ACT, THE CENTER ON HEALTH INS. REFORMS, GEORGETOWN UNIV. HEALTH POLICY INSTITUTE 10 (July 2013) (setting forth "benefit design features with the potential to be discriminatory" gleaned from interviews with state insurance regulators, representatives of national and local insurers, and consumer advocates).

323. *See supra* Part III (discussing medical necessity decisions); *see also, e.g.*, Letter from HIV Health Care Access Working Group to Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Sept. 30, 2013) (reporting that insurance "plans have systematically dropped people living with HIV from coverage for failure to pay premiums timely, while allowing healthier populations to remain in coverage"); Kari E. Hong, *Categorical Exclusions: Exploring Legal Responses to Health Care Discrimination Against Transsexuals*, 11 COLUM. J. GENDER & L. 88, 92 (2002) (reporting that insurance plans "deny transsexuals coverage for non-transition related, medically necessary conditions such as back pain, intestinal cysts, and even cancer, under the rationale that any medical care a transsexual needs is an excludable transsexual-related condition").

insurers to make eligibility determinations and to set premiums based on health status.[324] An insurer was allowed—indeed, sometimes required—to base its decisions about whether to offer coverage, and, if it chose to offer it, about how much to charge in premiums, on the amount it expected to pay out in benefits.[325]

As long as they did not rely on prohibited criteria, which varied by state, and as long as it was "actuarially fair" to do so, insurers were free to use underwriting and rating principles to exclude people with expensive medical conditions, including people with disabilities, from health insurance coverage.[326] In a 2013 letter to HHS, the BlueCross BlueShield Association defended such practices, explaining that "[w]hile some would argue that historic insurance practices such as charging a higher rate based on health status, varying premiums based on gender and/or age in the individual market, denying coverage based on a pre-existing condition, and not covering maternity coverage are discriminatory, these practices were necessary to avoid adverse selection in a voluntary insurance market."[327]

There are a number of examples from the past of insurance companies making decisions based on health status that, while perhaps fair in the actuarial sense, were widely considered to be unfair. In some cases, the argument has been made that insurers' decision-making was influenced by bias or stereotypes and was not, in fact, actuarially fair.[328]

324. *See* Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act,* 159 U. PENN. L. REV. 1577, 1597–98 (2011); *see also* Sharona Hoffman, *Unmanaged Care: Towards Moral Fairness in Health Care Coverage*, 78 INDIANA L. J. 659, 661–62 (2003); John V. Jacobi, *The Ends of Health Insurance,* 30 U.C. DAVIS L. REV. 311, 312–18 (1997).

325. *Id.*

326. Baker, *supra* note 324,at 1598.

327. Letter from Justine Handelman, Vice President, Legislative and Regulatory Policy, BlueCross BlueShield Assoc., to Leon Rodriguez, Director, Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Sept. 30, 2013), http://www.regulations.gov/#!documentDetail;D=HHS-OCR-2013-0007-0100; *see also* KATE GREENWOOD, RUTGERS CTR. FOR STATE HEALTH POL'Y & SETON HALL LAW CTR. FOR HEALTH & PHARM. LAW & POL'Y, THE AFFORDABLE CARE ACT'S RISK ADJUSTMENT AND OTHER RISK-SPREADING MECHANISMS: NEEDED SUPPORT FOR NEW JERSEY'S HEALTH INSURANCE EXCHANGE 3 (Aug. 2012), https://law.shu.edu/Health-Law/upload/affordable-care-act-risk-adjustment-9520.pdf ("Eliminating medical underwriting removes an important check on adverse selection, because individuals will know that if they wait until they get sick to purchase health insurance they will no longer be rejected or have to pay a high, perhaps unaffordably high, premium.").

328. *See* 4-13 THE LAW OF LIFE AND HEALTH INSURANCE § 13.06 (2014) ("Proponents of these measures may argue that, statistically, the class of the handicapped addressed are not really such bad risks as the insurers assert, and that stereotypes and bias govern the underwriting of such risks, making these handicapped persons the subject of unfair discrimination."); *see, e.g.*, Letter from Disability Rights Education & Defense Fund to Office for Civil Rights, U.S. Dep't of Health & Human Servs. 43 (Sept. 30,

For example, in the 1980s, HIV disease was new and feared, and it was expensive to treat.[329] Insurers and self-funded plans reacted to the fear of HIV and the cost of treatment of people with HIV disease by refusing to insure individuals who tested positive for HIV[330] and by excluding HIV disease-related care from coverage.[331] People with mental illness, genetic preconditions, and a history of injury from domestic violence similarly have been excluded from coverage.[332]

With the passage of the ACA, discriminating in health insurance on the basis of disability or illness is, for the most part, no longer permitted.[333] This does not mean that discrimination will not occur, however. This Part begins with a review of the pre-ACA laws addressing discrimination in health insurance and of the relevant provisions of the ACA. It then discusses the continuing potential for insurers to discriminate based on health status through "risk classification by design," which occurs when an insurer designs a health insurance plan to be appealing to relatively healthy individuals or unappealing to relatively sick individuals. Finally, this Part highlights the continuing concern that health insurance plans may discriminate, in design or implementation or both, against individuals in need of treatment for mental health or substance use disorders.

A. *The Intersection of Federal Anti-Discrimination Legislation and Health Insurance Practices Prior to the Passage of the ACA*

Many of the federal anti-discrimination statutes passed prior to the enactment of the ACA did not reach discrimination in the design or administration of health insurance plans. Title VI of the Civil Rights Act of 1964,[334] which prohibits discrimination based on "race, color, or national origin" in programs or activities that receive "Federal financial assistance,"[335] was passed, at least in part, "to put an end to 'separate, but

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2013), http://dredf.org/archived-site.shtml (alleging that the coverage limit for durable medical equipment in California's benchmark plan "is a clear and particular example of coverage discrimination against [people with disabilities] which has spread among small business insurers without any kind of actuarial justification or legal analysis").

329. Kenneth Vogel, *Discrimination on the Basis of HIV Infection: An Economic Analysis*, 49 OHIO ST. L.J. 965, 986 (1989).

330. Ronen Avraham et al., *Understanding Insurance Antidiscrimination Laws*, 87 S. CAL. L. REV. 195, 217–18 (2014); Vogel, *supra* note 329, at 991.

331. Vogel, *supra* note 329, at 991.

332. Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance,* 54 U. KAN. L. REV. 73, 99–107 (2005).

333. *See infra* Subsection V(D) and accompanying text.

334. Civil Rights Act of 1964 Title VI, 42 U.S.C. §§ 2000d–2000d-7.

335. 42 U.S.C. § 2000d (2012).

equal' access to health care."[336] Title VI explicitly states, however, that it does not apply to insurance contracts.[337] Similarly, Title IX of the Education Amendments of 1972,[338] which prohibits sex discrimination in federally-funded educational programs and activities, and the Age Discrimination Act of 1975,[339] which prohibits age discrimination in programs or activities receiving Federal financial assistance, do not apply to contracts of insurance.[340]

Section 504 of the Rehabilitation Act of 1973[341] prohibits discrimination based on disability, but only in government-funded programs or activities. In addition, § 504, at least arguably, does not apply to contracts of insurance.[342] The Americans with Disabilities Act ("ADA"),[343] which was passed in 1990, extends to and prohibits discrimination by private actors based on disabling health conditions. The ADA has a safe harbor provision, however, stating that the statute does not prohibit insurers "from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law[.]"[344]

By contrast, Title VII of the Civil Rights Act of 1964,[345] which prohibits discrimination in employment based on "race, color, religion, sex, or national origin," extends to employer-provided health benefits.[346] For example, as the U.S. Equal Employment Opportunity Commission explains on its website, "[a]ny health insurance provided by an employer must cover expenses for pregnancy related conditions on the same basis as expenses for other medical conditions."[347] The Age Discrimination in Employment Act of 1967[348] extends to employer-provided health

336. Ruqaiijah Yearby, *Breaking the Cycle of 'Unequal Treatment' with Health Care Reform: Acknowledging and Addressing the Continuation of Racial Bias*, 44 CONN. L. REV. 1281, 1289 (2012).

337. 42 U.S.C. § 2000d-4.

338. Education Amendments of 1972 Title IX, 20 U.S.C. §§ 1681–88.

339. Age Discrimination Act of 1975, 42 U.S.C. §§ 6101–6107 (2012).

340. 20 U.S.C. § 1685 (2012); 42 U.S.C. § 6103(a)(4) (2012).

341. Rehabilitation Act of 1973 § 504, 29 U.S.C. § 794 (2012).

342. 45 C.F.R. § 84.3(h) (2014) ("Federal financial assistance means any grant, loan, contract (other than a procurement contract or a contract of insurance or guaranty . . . ."). *But see* Moore v. Sun Bank of N. Florida, 923 F.2d 1423, 1429–32 (11th Cir. 1991) (finding that because Section 504 did not expressly exclude contracts of insurance or guaranty, the regulations containing the exclusion were invalid as inconsistent with congressional intent).

343. Americans with Disabilities Act, 42 U.S.C. §§ 12101–12213 (2012).

344. 42 U.S.C. § 12201(c).

345. Civil Rights Act of 1964 Title VII, 42 U.S.C. §§ 2000e–2000e-17.

346. 42 U.S.C. § 2000e-2(a).

347. *Pregnancy Discrimination*, U.S. EQUAL EMP'T OPPORTUNITY COMM'N, http://www.eeoc.gov/eeoc/publications/fs-preg.cfm (last visited Aug. 14, 2014).

348. Age Discrimination in Employment Act of 1967, 29 U.S.C. §§ 621–634 (2012).

benefits as well, but it "explicitly allows employers to provide older workers with lesser benefits than younger workers."[349]

The Health Insurance Portability and Accountability Act (HIPAA),[350] which was passed in 1996, was the first federal law that both (1) prohibited, in part, discrimination based on health status, and (2) applied to health insurance. HIPAA requires issuers of small-group health insurance to accept every small employer that applies for coverage,[351] and it requires issuers of individual, small, and large group insurance to "renew or continue in force such coverage" at the sole option of the individual or group.[352] HIPAA also makes it illegal for any group health plan to make an eligibility determination about an individual based on that individual's "health status-related factors" including, among other factors, current health status, medical history, and claims experience.[353] HIPAA also restricts the ability of group health plans to exclude pre-existing conditions from coverage.[354] In addition, group health plans may not, on the basis of a health status-related factor, "require any individual (as a condition of enrollment or continued enrollment under the plan) to pay a premium or contribution which is greater than such premium or contribution for a similarly situated individual enrolled in the plan[.]"[355] Professor Jessica Roberts summarizes the statute as follows: "HIPAA . . . outlaws excluding or medically underwriting *individuals* in the context of group health insurance."[356] HIPAA did not outlaw excluding or medically underwriting individuals in the context of individual health insurance, nor did it prevent issuers from varying the premiums they charged to

349. Crossley, *supra* note 332, at 96.

350. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (codified as amended in scattered sections of 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

351. 42 U.S.C. § 300gg-1(a). Issuers of small group health insurance are also required to "accept for enrollment every eligible individual . . . who applies for enrollment during the period in which the individual first becomes eligible to enroll under the terms of the group health plan and may not place any restriction which is inconsistent with section 2702 [prohibiting discrimination based on health status-related factors] on an eligible individual being a participant or beneficiary." Health Insurance Portability and Accountability Act § 2711, 42 U.S.C. § 300gg-11(a)(1)(B).

352. 42 U.S.C. § 300gg-2(a) (2012).

353. 26 U.S.C. § 9802(a)(1)(A)–(H) (2012); 29 U.S.C. § 1182(a)(1)(A)–(H) (2012); 42 U.S.C. § 300gg-4(a)(1)–(9) (2012).

354. 26 U.S.C. § 9801(a) (2012); 29 U.S.C. § 1181(a) (2012); 42 U.S.C. § 300gg-3(a) (1996).

355. 26 U.S.C. § 9802(b)(1) (2012); 29 U.S.C. § 1182(b)(1) (2012); 42 U.S.C. § 300gg(a)(1)(A)–(B)(2012).

356. Roberts, *supra* note 321, at 1180.

small groups based on the health status of the groups' individual members.

Unlike HIPAA, the Genetic Information Nondiscrimination Act of 2008 (GINA)[357] applies to individual as well as to group health plans,[358] but it only bans discrimination based on genetic information. Under GINA, health insurers cannot request, require, purchase, or use genetic information for underwriting purposes, treat genetic information as a preexisting condition, or adjust premium or contribution amounts on the basis of genetic information.[359] As Professor Roberts explains, GINA "represents a move away from a purely economic approach to health insurance to an antidiscrimination model" because it "restricts a health insurer from considering a certain type of health-related information, even though assessing that information would facilitate more accurate risk assessment."[360]

In the years prior to the passage of the ACA, individual states took a number of steps to address discrimination in health insurance. Some states passed legislation based on the NAIC's model Unfair Trade Practices Act, which prohibits "any unfair discrimination between individuals of the same class and of essentially the same hazard in the amount of premium, policy fees or rates charged for any accident or health insurance policy or in the benefits payable thereunder, or in any of the terms or conditions of such policy, or in any other manner."[361] The NAIC Model Act also prohibits "refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual

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357. Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, 122 Stat. 881 (codified as amended in scattered sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

358. 26 U.S.C. § 9802 (2012); 29 U.S.C. § 1182 (2012); 42 U.S.C. § 300gg-4 (2012); 42 U.S.C. § 300gg-53 (2012).

359. *See* 29 U.S.C. 1182(b)(3)(A)—(d)(3) (2012); 42 U.S.C. § 300gg-4(b)(3)–(d)(3); 42 U.S.C. § 300gg-53(a)–(e) (2012).

360. Roberts, *supra* note 321, at 1184.

361. NAT'L ASS'N OF INS. COMM'RS, UNFAIR TRADE PRACTICES ACT § 4(G)(2) (Jan. 2004), http://www.naic.org/store/free/MDL-880.pdf (listing states that have adopted the Model Act in whole or in part as of April 2014). States also have passed laws based on the NAIC's Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Physical or Mental Impairment and on its Model Regulation on Unfair Discrimination in Life and Health Insurance on the Basis of Blindness or Partial Blindness. NAT'L ASS'N OF INS. COMM'RS, MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF PHYSICAL OR MENTAL IMPAIRMENT (June 1979), http://www.naic.org/store/free/MDL-887.pdf (listing states that have adopted the model regulation in whole or in part as of January 2014); NAT'L ASS'N OF INS. COMM'RS, MODEL REGULATION ON UNFAIR DISCRIMINATION IN LIFE AND HEALTH INSURANCE ON THE BASIS OF BLINDNESS OR PARTIAL BLINDNESS (Apr. 1997), http://www.naic.org/store/free/MDL-888.pdf (listing states that have adopted the model regulation in whole or in part as of January 2014).

because of the sex, marital status, race, religion or national origin of the individual."[362]

B. Federal and State Mental Health Parity Laws

Prior to the ACA, federal and state laws were passed that specifically targeted discrimination against behavioral and mental health treatment in insurance. At the federal level, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA),[363] which was passed in 2008, built upon groundwork laid by earlier legislation, the Mental Health Parity Act of 1996 (MHPA).[364] The MHPAEA required large group insurance plans that offered mental health and substance use disorder benefits to offer the same annual or lifetime dollar limits, treatment or visit limits, cost-sharing, and access to out-of-network care as they did for medical or surgical benefits.[365]

While many states passed mental health parity laws as well, gaps remained.[366] As discussed in the next Subsection, the ACA fills many of the gaps left by previous legislation, extending, in the words of Professor Tom Baker, "the nondiscrimination vision of what constitutes a fair share from the large-group market to the individual and small-group market[s]."[367]

C. The Anti-Discrimination Provisions of the ACA

The ACA extended the MHPAEA to all health insurance plans in the individual market.[368] In addition, as discussed above in Part II(B), most individual and small-group health insurance plans must provide

362. NAT'L ASS'N OF INS. COMM'RS,UNFAIR TRADE PRACTICES ACT § 4(G)(5), *supra* note 361.

363. Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Pub. L. No. 110-343, §§ 511–12, 122 Stat. 3765 (codified as amended at 29 U.S.C. § 1185a (2012) & 42 U.S.C. § 300gg-26 (2012)).

364. Mental Health Parity Act of 1996, Pub. L. No. 104-204, §§ 701–03, 110 Stat. 2944 (codified as amended at 29 U.S.C. § 1185a & 42 U.S.C. § 300gg-26).

365. *See* Sarah Goodell, *Health Policy Brief: Mental Health Parity*, HEALTH AFFAIRS 2 (Apr. 3, 2014), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_112.pdf.

366. Stacey A. Tovino, *Reforming State Mental Health Parity Law*, 11 HOUS. J. HEALTH L. & POL'Y 455, 457 (2012) (explaining that state mental health parity laws "vary widely in their application and scope").

367. Baker, *supra* note 324, at 1602.

368. *See* 42 U.S.C. § 300gg-26 (2012) (explaining in accompanying notes that the ACA substituted language referring to issuers offering both individual and group health insurance plans for language referring solely to issuers offering group health insurance plans); *see also* § 1311(j) (providing that "Section 2726 of the Public Health Service Act [42 USCS § 300gg-26] shall apply to qualified health plans in the same manner and to the same extent as such section applies to health insurance issuers and group health plans").

coverage of mental health and substance use disorder services as one of the ten categories of essential health benefits required by the ACA.[369] As the Department of Labor has explained, the essential health benefits regulations require non-grandfathered plans in both the individual and small-group markets "to comply with the requirements of the parity regulations to satisfy the requirement to provide EHB."[370]

The ACA is also the first federal law that directly addresses and bans discrimination in health insurance on the basis of health status. Section 1201 of the ACA restricts (1) the grounds on which "group health plan[s]" and "health insurance issuers offering group or individual health insurance coverage" can base eligibility determinations; and (2) the grounds on which they can charge higher premiums.[371] Issuers are barred from establishing "rules for eligibility"[372] and from charging higher premiums based on the following factors: (1) health status; (2) medical condition (including both physical and mental illnesses); (3) claims experience; (4) receipt of health care; (5) medical history; (6) genetic information; (7) evidence of insurability (including conditions arising out of acts of domestic violence); (8) disability; and (9) any other health status-related factor determined appropriate by the Secretary.[373]

The regulations implementing § 1201 generally approve of health insurer actions to the extent that they are "applied uniformly to all

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369. *See supra* Part II(B).

370. *FAQs About Affordable Care Act Implementation Part XVIII and Mental Health Parity Implementation*, U.S. DEP'T OF LABOR, http://www.dol.gov/ebsa/faqs/faq-aca18.html (last visited July 13, 2015).

371. 42 U.S.C. § 300gg-4.

372. "Rules for eligibility" is defined broadly, to include "(A) Enrollment; (B) The effective date of coverage; (C) Waiting (or affiliation) periods; (D) Late and special enrollment; (E) Eligibility for benefit packages (including rules for individuals to change their selection among benefit packages); (F) Benefits (including rules relating to covered benefits, benefit restrictions, and cost-sharing mechanisms such as coinsurance, copayments, and deductibles) . . . ; (G) Continued eligibility; and (H) Terminating coverage (including disenrollment) of any individual under the plan." 45 C.F.R. § 146.121(b)(1)(ii) (2014).

373. Section 1201's implementing regulations provide that in addition to acts of domestic violence, "evidence of insurability" includes "[p]articipation in activities such as motorcycling, snowmobiling, all-terrain vehicle riding, horseback riding, skiing, and other similar activities." *Id.* § 146.121 (a)(2)(ii). The ACA permits insurers to vary the premiums they charge based on four factors: (1) whether a plan covers an individual or family; (2) what the plan's geographic rating area is; (3) how old the insured individual is (but then only by up to a factor of three to one); and (4) whether the insured individual uses tobacco (but then only by a factor of up to 1.5 to 1). *See* 42 U.S.C. § 300gg(a)(1)(A); *see also* TARA ADAMS RAGONE, RUTGERS CENTER FOR STATE HEALTH POLICY & SETON HALL LAW CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY, EVALUATING FEDERAL AND NEW JERSEY REGULATION OF RATING FACTORS AND RATE BANDS 6-7 (Aug. 2012), http://www.cshp.rutgers.edu/publications/evaluating-federal-and-new-jersey-regulation-of-rating-factors-and-rate-bands.

similarly situated individuals" and are "not directed at individual participants or beneficiaries."[374] The regulations allow health insurance plans to:

> limit or exclude benefits in relation to a specific disease or condition, limit or exclude benefits for certain types of treatments or drugs, or limit or exclude benefits based on a determination of whether the benefits are experimental or not medically necessary, but only if the benefit limitation or exclusion applies uniformly to all similarly situated individuals and is not directed at individual participants or beneficiaries based on any health factor of the participants or beneficiaries.[375]

A second provision of the ACA, § 1557, provides that "any health program or activity" that receives federal funds may not discriminate against individuals on any ground prohibited under Title VI of the Civil Rights Act (race, color, or national origin), Title IX of the Education Amendments (sex), the Age Discrimination Act (age), or § 504 of the Rehabilitation Act (disability).[376] Unlike other anti-discrimination laws, § 1557 explicitly states that it applies where the federal funds in question consist of "credits, subsidies, or contracts of insurance."[377]

In September 2015, HHS released draft regulations implementing § 1557.[378] The preamble to the draft regulations clarifies that § 1557's anti-discrimination prohibition applies broadly,

> to all issuers that receive Federal financial assistance, whether those issuers' products are offered through the Marketplace, outside the Marketplace, in the individual or group health insurance markets, or as an employee health benefit program through an employer-sponsored group health plan. Thus, for example, an issuer that participates in the Marketplace and thereby receives Federal financial assistance, and that also offers plans outside the Marketplace, will be covered by the proposed regulation for all of its health plans, as well as when it acts as a third party administrator for an employer-sponsored group health plan.[379]

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374. 45 C.F.R. § 146.121; *see also id.* §147.110 (explaining that, with the exception of wellness programs, the provisions of 45 C.F.R. § 146.121 apply to the individual market as well).

375. *Id.* § 146.121(b)(2)(B).

376. 42 U.S.C. § 18116(a).

377. *Id.*

378. Nondiscrimination in Health Programs and Activities,80 Fed. Reg. 54,172, 54,172-221 (proposed Sept. 8, 2015) (to be codified at 45 C.F.R. pt. 92).

379. *Id.* at 54,189.

The preamble states that HHS is aware of least 180 health insurance issuers that are participating in the Federally-facilitated and State-based marketplaces and so are covered by § 1557.[380]

The draft regulations contain a provision addressing discrimination by health insurance issuers, 45 C.F.R. § 92.207, but it offers few specifics.[381] Timothy Jost and other commenters have expressed surprise that "the proposed rule does not directly address one of the most salient current discrimination questions: whether insurers can impose high cost sharing or otherwise limit access to expensive drugs needed by certain disabled populations, like persons with AIDS."[382]

Discrimination is also addressed in other provisions of the ACA and in their implementing regulations. The statutory section setting forth the EHB requirement provides that, in defining the requirement, "the Secretary shall . . . not make coverage decisions, determine reimbursement rates, establish incentive programs, or design benefits in ways that discriminate against individuals because of their age, disability, or expected length of life[.]"[383] The same provision goes on to require that the Secretary, in defining EHB, "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups" and "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life."[384]

The regulations implementing the EHB requirement state that "[a]n issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions."[385] This general rule against discrimination on the basis of health is subject to the caveat

380. *Id.* at 54,198.

381. *Id.* at 54,219–20. The draft version of § 92.207 does offer the following specific examples of illegal sex discrimination in insurance, providing that issuers cannot "[c]ategorically or automatically exclude from coverage, or limit coverage for, all health services related to gender transition; or [o]therwise deny or limit coverage, or deny a claim, for specific health services related to gender transition if such denial or limitation results in discrimination against a transgender individual." *Id.* at 54,220.

382. *See* Timothy Jost, *Implementing Health Reform: HHS Proposes Rule Implementing Anti-Discrimination ACA Provisions (Contraceptive Coverage Litigation Update)*, HEALTH AFFAIRS BLOG (Sept. 4, 2015, 1:00 PM), http://healthaffairs.org/blog/2015/09/04/implementing-health-reform-hhs-proposes-rule-implementing-anti-discrimination-aca-provisions/.

383. 42 U.S.C. § 18022(b)(4)(B) (2012).

384. *Id.* § 18022(b)(4)(C)–(D).

385. 45 C.F.R. § 156.125(a) (2014).

that "[n]othing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques."[386] The regulations governing QHPs provide that an "issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation."[387] A separate provision extends the requirement to any issuer "providing EHB."[388]

As discussed above in Part II.C, beginning in 2017, plans will not be considered to be providing EHB unless they use a P&T committee to determine which drugs to include on their formularies.[389] Among other things, the P&T committee will be responsible for ensuring that the plan's formulary "[c]overs a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and *does not discourage enrollment by any group of enrollees*[.]"[390] Also beginning in 2017, plans must, with certain exceptions, give enrollees the option of purchasing their medications at a brick-and-mortar pharmacy.[391] In the preamble to the Notice of Benefit and Payment Parameters for 2016, CMS noted "that making drugs available only by mail order could discourage enrollment by, and thus discriminate against, transient individuals and individuals who have conditions they wish to keep confidential."[392]

The statute and regulations also address discriminatory marketing practices. The statute bars a plan from "employ[ing] marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs."[393] The regulations elaborate on this, requiring that issuers:

> must comply with any applicable state laws and regulations regarding marketing by health insurance issuers and cannot employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in health insurance coverage or discriminate based on an individual's race, color, national origin, present or predicted disability, age, sex, gender

386. *Id.* § 156.125(c).
387. *Id.* § 156.200(e) (2014).
388. *Id.* § 156.125(b).
389. *Id.* § 156.122(a)(3).
390. *Id.* § 156.122(a)(3)(iii)(H)(1) (emphasis added).
391. *Id.* §156.122(e).
392. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,821 (Feb. 27, 2015).
393. 42 U.S.C. § 18031(c)(1)(A) (2012).

identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.[394]

D. *The Continuing Possibility of Health Status Discrimination*

With the passage and implementation of the ACA, it might be expected that few, if any, insurance plans will overtly discriminate on the basis of prohibited criteria, including potentially "actuarially fair" criteria such as current health status or medical history. As Professor Baker has noted, the ACA's guaranteed issue and renewal requirements[395] "eliminate the traditional authority of health insurance companies to choose whom they will insure[.]"[396] Moreover, the prohibition on preexisting condition exclusions[397] eliminates their authority to choose which risks they will insure against. The ACA does not, however, entirely eliminate insurers' incentive to attract low-risk consumers and avoid high risk (including disabled or chronically ill) consumers.

1. Risk Classification by Design

Issuers may respond to this incentive by discriminating in a subtle way, adopting plan features designed to make the plans more attractive to the low-risk consumers whom the issuers wish to attract, and less attractive to the high-risk consumers whom they do not. Professor Baker's term for this subtle form of discrimination is "risk classification by design."[398] As Professor Baker describes it, "insurance products can be designed to appeal differentially to people with different risk characteristics, so that people self-select into separate risk pools in a manner that correlates with their risk status."[399]

Consider, for example, a state or region with an array of cancer specialists and facilities. Many of the providers may be well-qualified to provide services, but one facility or provider stands out as a true center of excellence. Should a self-interested insurer include the center of excellence in its network? The theory of risk classification by design suggests that the answer may be no–even if the center of excellence can

394. 45 C.F.R. § 147.104(e); *see also id.* § 156.225 ("A QHP issuer and its officials, employees, agents and representatives must—(a) State law applies. Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and (b) Non-discrimination. Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.").

395. 42 U.S.C. § 300gg-1(a)-(b)(1) (2012); *id.* § 300gg-2(a).

396. Baker, *supra* note 324, at 1588.

397. 42 U.S.C. § 300gg-3.

398. Baker, *supra* note 324, at 1580.

399. *Id.* at 1610.

provide very good cancer care at a reasonable price–because by including it the issuer may make its plan more attractive to high-cost cancer patients. It could be in the insurer's best interest, instead, to include cancer facilities and specialists in its network (to meet regulatory requirements or general consumer expectations) but not the center of excellence.

Professor Baker points to four ways in which the ACA reduces the potential for insurers to discriminate on the basis of health status through risk classification by design.[400] First, as discussed in Part II above, the ACA "set[s] a floor for contract quality standards on the health plans that may be offered in the individual and small-group market."[401] Plans must cover essential health benefits,[402] subject to limits on enrollee cost-sharing.[403] Plans must also meet one of the four "actuarial value" or metal level requirements, which are denoted bronze, silver, gold, and platinum.[404] Professor Baker writes that "by reducing the range of variation among plans, the[se] minimum standards reduce the room for" risk classification by design.[405]

Second, there are the ACA's risk adjustment, risk corridors, and reinsurance provisions, which were designed, in part, to reduce the losses issuers sustain from enrolling relatively high-risk individuals, and to ensure that they do not benefit, or benefit less than they otherwise would, from enrolling relatively low-risk individuals.[406] As Professor Baker explains, if risk adjustment works as hoped, plans will not have an incentive to try to attract relatively low-risk individuals because their net premiums after adjustment will reflect the entire market's risk pool, "rather than the pool of the particular plan."[407]

The third aspect of the ACA that counteracts the tendency of issuers to engage in risk classification by design is the medical loss ratio requirement, which plays a similar role to risk adjustment, reducing the short-term profits insurers can earn from enrolling low-risk individuals who need relatively little medical care.[408] Professor Baker argues that

400. *Id.* at 1611–15.
401. *Id.* at 1587.
402. 42 U.S.C. § 18022(a) & (b).
403. *Id.* § 18022(c).
404. *Id.* § 18022(d).
405. Baker, *supra* note 324, at 1588.
406. GREENWOOD, *supra* note 327, at ii.
407. Baker, *supra* note 324, at 1614.
408. TARA ADAMS RAGONE, RUTGERS CENTER FOR STATE HEALTH POLICY & SETON HALL LAW CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY, THE AFFORDABLE CARE ACT AND MEDICAL LOSS RATIOS: FEDERAL AND STATE METHODOLOGIES iii (May 2012), http://www.cshp.rutgers.edu/publications/the-affordable-care-act-and-medical-loss-ratios-federal-and-state-methodologies.

the medical loss ratio actually encourages insurers to enroll high-risk individuals.[409] The fact that a percentage of the medical expenses of a high-risk population is more than a percentage of the medical expenses for a low-risk population leaves "more money to pay for the CEO's jet."[410]

The fourth and final aspect of the ACA that Professor Baker points to as reducing the potential for risk classification by design is what he calls the exchange certification requirement.[411] Before a health plan may be certified as qualified to be sold on an exchange, the exchange must determine that making it available "is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates[.]"[412] Professor Baker suggests that exchanges consider whether a plan is deliberately designed to lead to risk classification in making the decision whether to certify it.[413]

In its 2015 Letter to Issuers, CMS explained its approach to ensuring "compliance with nondiscrimination standards" in FFMs, an approach which it encouraged state-run exchanges to use as well.[414] CMS wrote:

> [t]o ensure non-discrimination in QHP benefit design, CMS will perform an outlier analysis on QHP cost-sharing (e.g., co-payments and co-insurance) as part of the QHP certification application process. QHPs identified as outliers may be given the opportunity to modify cost sharing for certain benefits if CMS determines that the cost sharing structure of the plan that was submitted for certification could have the effect of discouraging the enrollment of individuals with significant health needs.[415]

Among the benefits CMS expected to compare with regard to cost-sharing are inpatient hospital stays, inpatient mental/behavioral health stays, specialist visits, emergency room visits, and prescription drugs.[416] The agency explained that "[d]iscriminatory cost-sharing language would typically involve reduction in the generosity of a benefit in some manner for subsets of individuals other than based on clinically indicated common medical management practices."[417] With regard to prescription drug coverage, the agency expected to focus on "plans that are outliers

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409. Baker, *supra* note 324, at 1614.
410. *Id.*
411. *Id.* at 1611–12.
412. 42 U.S.C. § 18031(e)(1) (2012).
413. Baker, *supra* note 324, at 1612.
414. CMS, *2015 Letter to Issuers*, *supra* note 69, at 27.
415. *Id.* at 28.
416. *Id.*
417. *Id.* at 29.

based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular category and class."[418]

In the preamble to the Notice of Benefit and Payment Parameters for 2016, CMS reiterated its commitment to "notify[ing] an issuer when we see an indication of a reduction in the generosity of a benefit in some manner for subsets of individuals that is not based on clinically indicated, reasonable medical management practices."[419] The agency also highlighted "three examples of potentially discriminatory practices" that could require "further investigation by the enforcing entity."[420] The three examples were as follows: "(1) [a]ttempts to circumvent coverage of medically necessary benefits by labeling the benefit as a 'pediatric service,' thereby excluding adults; (2) refusal to cover a single-tablet drug regimen or extended-release product that is customarily prescribed and is just as effective as a multi-tablet regimen, absent an appropriate reason for such refusal; and (3) placing most or all drugs that treat a specific condition on the highest cost tiers."[421]

CMS' third example echoes a complaint filed on May 29, 2014, with the Office of Civil Rights of HHS by the National Health Law Program and The AIDS Institute, a Tampa-based non-profit, alleging that four of the thirty-six silver level QHPs offered in Florida "charge inordinately high co-payments and co-insurance for medications used in the treatment of HIV and AIDS."[422] Each of the four plans was alleged to place all HIV drugs, branded and generic, on the plan's least-preferred tier, requiring enrollees to make coinsurance payments of forty to fifty percent of the retail cost of the drug.[423] Some enrollees also were subject to deductibles.[424] Finally, for at least three of the four plans, medications

418. *Id.* at 28.

419. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10822–23 (Feb. 27, 2015).

420. *Id.*

421. *Id.* at 10,822.

422. THE AIDS INSTITUTE AND THE NATIONAL HEALTH LAW PROGRAM, ADMINISTRATIVE COMPLAINT RE: DISCRIMINATORY PHARMACY BENEFITS DESIGN IN SELECT QUALIFIED HEALTH PLANS OFFERED IN FLORIDA 2–3 (MAY 29, 2014), http://www.healthlaw.org/publications/browse-all-publications/HHS-HIV-Complaint#.U_1BmGPp-Uk [hereinafter ADMINISTRATIVE COMPLAINT]. According to an August 6, 2014 Associated Press article, advocates in Georgia are planning to file a similar complaint, and advocates in California, Illinois, and Ohio have said that exchange plans in their states have issues similar to the issues in Florida. Kelli Kennedy, *AIDS Patients Fear Discrimination in ACA Exchange*, ASSOCIATED PRESS (Aug. 6, 2104, 5:22 PM), http://news.yahoo.com/aids-patients-fear-discrimination-aca-exchange-212246484.html.

423. ADMINISTRATIVE COMPLAINT, *supra* note 422, at 8–9.

424. *Id.*

placed in the least-preferred tier were subject to prior authorization requirements and quantity limits.[425]

The complainants wrote that "[t]he practice of placing all anti-retrovirals on the highest tier is not a market norm or necessity."[426] In support of this argument, they pointed to the fact that "[o]ther issuers [of Florida QHPs] vary tiering or place HIV drugs on more affordable tiers."[427] The complainants contended that the four plans' treatment of HIV drugs will "discourage people living with HIV and AIDS from enrolling in those health plans–a practice which unlawfully discriminates on the basis of disability."[428] Each of the four plans identified in the complaint has entered into settlement agreements with the Florida Office of Insurance Regulation, while denying that they engaged in illegal discrimination.[429] HHS' investigation is ongoing.[430]

Spurred by the complaint brought by The AIDS Institute and the National Health Law Program, the pharmaceutical industry trade association, PhRMA, engaged the consulting firm Avalere Health to analyze the formularies of 123 silver marketplace plans.[431] Avalere Health focused on the out-of-pocket expense patients could face for each drug, whether branded or generic, in nineteen different drug classes.[432] It found that 52 percent of silver plans require coinsurance of 30 percent or higher for all covered drugs in at least one class, while 39 percent of silver plans require coinsurance of 40 percent or higher for all covered drugs in at least one class.[433] Avalere Health also found that 86 percent of silver plans place all covered drugs in at least one class on the highest formulary tier.[434]

Avalere Health's analysis suggests that people with HIV and AIDS are not alone. In a summary of the analysis, PhRMA notes that:

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425. *Id.*

426. *Id.* at 10.

427. *Id.*

428. *Id.* at 3.

429. Nicholas Nehamas, *Preferred Voluntarily Caps HIV Drug Prices*, MIAMI HERALD (Jan. 21, 2015), http://www.miamiherald.com/news/health-care/article7893084.html.

430. *Id.*

431. AVALERE HEALTH, AN ANALYSIS OF CERTAIN EXCHANGE PLAN BENEFITS 5 (June 2014), http://www.phrma.org/sites/default/files/20140521_FINAL%20PhRMA_High%20Coinsurance%20and%20Tier%20Placement_Avalere%5B7a%5D_0.pdf.

432. PHRMA, COVERAGE WITHOUT ACCESS: AN ANALYSIS OF EXCHANGE PLAN BENEFITS FOR CERTAIN MEDICINES, http://www.phrma.org/affordable-care-act/coverage-without-access-an-analysis-of-exchange-plan-benefits-for-certain-medicines#sthash.o0bB3Xh0.pdf (last visited Aug. 15, 2014) [hereinafter COVERAGE WITHOUT ACCESS].

433. AVALERE HEALTH, *supra* note 431, at 2–3.

434. *Id.* at 4.

> [i]n seven classes, more than 20 percent of the plans require coinsurance of 40 percent or more for *all* medicines in the class. Over 60 percent of the plans place all covered medicines in the class for treating multiple sclerosis on the formulary tier with the highest cost sharing. Similarly, over 60 percent of the plans place all covered medicines in certain classes for treating cancer on the formulary tier with the highest cost sharing.[435]

PhRMA contends that these findings "suggest a lack of adequate formulary scrutiny on the part of state and federal regulators" because "[r]equiring high cost sharing for all medicines in a class is exactly the type of practice the ACA was designed to prevent."[436] When Katie Keith and colleagues at the Center for Health Insurance Reforms at the Georgetown University Health Policy Institute interviewed state regulators about the potential for discriminatory formulary designs, however, some argued that in-depth scrutiny of drug formularies "would be an expansion of their traditional regulatory role because it requires an understanding of the latest drug treatments, patient needs, and evidence-based treatments."[437]

2. The Challenges of Putting Mental Health Parity into Practice

As mental health parity is put into practice across a broad array of health insurance plans, disputes are likely to arise. Eric Goplerud, of the independent research organization NORC at the University of Chicago, has observed that "[t]he history of parity legislation shows that implementation of requirements in this area is not always straightforward and ensuring equitable treatment of mental health (MH) and substance use disorder (SUD) treatment is often complicated."[438] In a recent Health Affairs Health Policy Brief, Sarah Goodell quoted a health insurance executive who commented that "[h]ow to provide coverage for care levels and treatment venues that are unique to behavioral health, and aligning these with medical and surgical benefits, is a continuing discussion within health plans and between plans and regulators."[439]

A study of large group plans' compliance with the MHPAEA that Goplerud conducted for HHS in November 2013 revealed that 20 percent of such plans required higher copayments, and four percent required

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435. COVERAGE WITHOUT ACCESS, *supra* note 432.

436. *Id.*

437. KEITH ET AL., *supra* note 322, at 11.

438. ERIC GOPLERUD, CONSISTENCY OF LARGE EMPLOYER AND GROUP HEALTH PLAN BENEFITS WITH REQUIREMENTS OF THE PAUL WELLSTONE AND PETE DOMENICI MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 vii (Nov. 2013).

439. Goodell, *supra* note 365, at 4.

more in coinsurance for in-network outpatient MH/SUD services than for equivalent medical or surgical care.[440] Goplerud also found that "although the percentage of plans with more restrictive treatment limitations dropped substantially since the introduction of MHPAEA, a minority of plans in our post-parity sample, between seven percent and nine percent, still covered fewer MH and SUD inpatient days annually and fewer MH and SUD outpatient visits annually than they covered for medical/surgical conditions."[441] Less obvious inequities in plan design may persist as well. For example, plans may continue to use different approaches to determining medical necessity for behavioral and mental health treatments, they may incorporate step therapy or "fail first" requirements that do not apply to physical health treatments, and they may require prior authorization for behavioral and mental health treatments beyond what is required for physical health treatments.[442]

Even if plans are equitable on paper, discrimination may occur in their administration. In July of 2014, for example, the New York State Attorney General announced that an investigation it conducted revealed that "since at least 2011, EmblemHealth, through its behavioral health subcontractor, Value Options, issued sixty-four percent more denials of coverage in behavioral health cases than in medical cases."[443] The investigation also showed that EmblemHealth "did not cover residential treatment for behavioral health conditions . . . while covering similar treatment–skilled nursing, for example–for medical conditions."[444] The Attorney General highlighted a case in which EmblemHealth "denied coverage of residential treatment for a young woman with a severe case of anorexia nervosa, a potentially life-threatening condition" and "only agreed to cover the treatment after the Attorney General's Health Care bureau intervened."[445] EmblemHealth also improperly denied coverage of residential treatment for individuals with substance use disorders, requiring enrollees to have recently tried and failed an outpatient program, for example, or to be experiencing "life-threatening

440. GOPLERUD, *supra* note 438, at xii.

441. *Id.*

442. Letter from James H. Scully, Jr., Medical Director and Chief Executive Officer, American Psychiatric Assoc., to Leon Rodriguez, Director, Office for Civil Rights, U.S. Dep't of Health & Human Servs. (Sept. 30, 2013) [hereinafter Scully Letter], http://www.regulations.gov/#!documentDetail;D=HHS-OCR-2013-0007-0091.

443. Press Release, New York State Office of the Attorney General, A.G. Schneiderman Announces Settlement With Emblem Health For Wrongly Denying Mental Health And Substance Abuse Treatment For Thousands Of New York Members (July 9, 2014), http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-emblem-health-wrongly-denying-mental-health-and.

444. *Id.*

445. *Id.*

withdrawal" before approving an inpatient stay.[446] Notably, the Attorney General's settlement with EmblemHealth is one of a total of five mental health parity settlements that the New York State Attorney General has reached with insurers since 2014.[447]

Disputes over the level and duration of treatment that is medically necessary for individuals with substance use disorders may be particularly frequent. In a March 2014 news article, Jayne O'Donnell reported that "treatment centers say disagreement over [parity] leaves many alcoholics and drug addicts without the coverage they need."[448] A study conducted by the National Association of Addiction Treatment Professionals of 800 disputes between insurance companies and providers over such treatment found that "89% of disagreements over whether treatment was on par with what would be covered for medical issues such as diabetes or heart disease were related to detox, [i]npatient or residential treatment."[449]

A 2013 analysis of commercial insurance plans by the Treatment Research Institute for the American Society of Addiction Medicine ("ASAM") found significant barriers for enrollees seeking coverage of Food and Drug Administration-approved medications to treat opioid dependence.[450] The Treatment Research Institute found that these

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446. *Id.*

447. *See id.*; Press Release, N.Y. State Office of the Attorney General, A.G. Schneiderman Announces Settlement With Excellus Health Plan To End Wrongful Denial Of Mental Health And Addiction (Mar. 18, 2015), http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-excellus-health-plan-end-wrongful-denial-mental; Press Release, N.Y. State Attorney General, A.G. Schneiderman Announces Settlement With ValueOptions To End Wrongful Denial Of Mental Health And Substance Abuse Treatment Services (Mar. 5, 2015), http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-valueoptions-end-wrongful-denial-mental-health; Press Release, N.Y. State Office of the Attorney General, A.G. Schneiderman Announces Settlement With Health Insurer That Wrongly Denied Mental Health Benefits To Thousands Of New Yorkers (Mar. 20, 2014), http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-health-insurer-wrongly-denied-mental-health (announcing settlement with MVP Health Care); Press Release, N.Y. State Office of the Attorney General, A.G. Schneiderman Announces Settlement With Health Care Insurer For Wrongfully Denying Mental Health Treatment Claims (Jan. 15, 2014), http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-health-care-insurer-wrongfully-denying-mental (announcing settlement with Cigna Corporation).

448. Jayne O'Donnell, *Is Substance Abuse Coverage as Equal as Required?*, USA TODAY (Mar. 10, 2014, 10:04 PM), http://www.usatoday.com/story/news/nation/2014/03/10/substance-abuse-treatment-coverage-obamacare/6176881/.

449. *Id.*

450. *See generally* MADY CHALK ET AL., ADVANCING ACCESS TO ADDICTION MEDICATION: IMPLICATIONS FOR OPIOID ADDICTION TREATMENT, REPORT OF COMMERCIAL HEALTH PLAN MEDICATION COVERAGE AND BENEFITS SURVEY, TREATMENT RESEARCH INSTITUTE (TRI) (2013), http://www.tresearch.org/tri-contributes-to-american-society-of-

medications were subject to a variety of utilization management techniques including prior authorization requirements, "fail first" requirements, and limits on dosage and prescription duration.[451] Not one of the commercial plans studied covered methadone maintenance therapy.[452]

3. The Need for Enforcement

Many commentators have identified concerns that forms of discrimination could arise that might be difficult to discern. Professor Baker has pointed to the risk that insurers could marginally improve the risk profile of their insured pool by engaging in "risk classification by design."[453] Although he points to features in the ACA that may blunt the likelihood of this form of discrimination,[454] it will be important for researchers to evaluate the extent to which the statute succeeds in encouraging non-discriminatory behavior.

CMS has announced an approach to uncover discriminatory practices by reviewing–and encouraging marketplace officials to review–the proportionality of the allocation of cost-sharing among modes of service.[455] If examination shows that costs inequitably burden people with particular vulnerabilities, CMS will take action.[456] This is an important initiative, but it will not uncover other aspects of insurance plans that might be unfairly discriminatory.[457]

Recent complaints have raised concerns about whether formulary design in some plans disproportionately burdens people with HIV disease or other chronic conditions.[458] Close attention to the effects of formulary design and other market behavior of insurers will be crucial to uncover potentially problematic conduct that could constitute unlawful discrimination. It is likely that most of such conduct, if it occurs, will be relatively subtle, and will only be revealed through attentive review of the marketplace by advocates, researchers, and regulators.

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addiction-medicines-review-of-advancing-access-to-addiction-mediations-implications-for-opioid-addiction-treatment/.

451. *Id.* at 17.

452. *Id.* at 19. A review by the American Psychiatric Association found that some states' benchmark plans excluded or limited access to addiction medications, including California's benchmark plan, which covers methadone but only for pregnant women. Scully Letter, *supra* note 442.

453. *See supra* note 398 and accompanying text.

454. *See supra* notes 400-413 and accompanying text.

455. *See supra* notes 414-418 and accompanying text.

456. *See supra* note 415 and accompanying text.

457. *See supra* notes 399 and accompanying text.

458. *See supra* note 422-430 and accompanying text.

Numerous regulators have a role to play in enforcing the ACA's prohibitions on discrimination. In general, the states have the authority to enforce the ACA's health insurance-related requirements.[459] CMS steps in where "a State has failed to substantially enforce a provision (or provisions) in this part with respect to health insurance issuers in the State[.]"[460] In addition, as discussed above, the FFM and the state Exchanges can use their certification authority to ensure that QHPs are not intentionally designed to attract low-risk enrollees.[461] State insurance departments can play a similar role for plans offered for sale outside of the exchanges.

HHS' Office for Civil Rights ("OCR") is charged with enforcing the various federal laws that prohibit discrimination in health care programs.[462] On its website, OCR announces that it "is responsible for enforcing Section 1557" and that it "has been accepting and investigating complaints under this authority."[463] The Department of Justice ("DOJ") coordinates the enforcement of all of the federal antidiscrimination laws by all of the executive agencies, including HHS.[464] DOJ can also bring suit to enforce the antidiscrimination laws.[465] In addition, individuals harmed by discrimination can bring private lawsuits for money damages and equitable relief, such as a court order directing a health insurer to stop using a discriminatory plan design.[466]

Section 1557 provides that "[t]he enforcement mechanisms provided for and available under Title VI, Title IX, section 504, or such Age Discrimination Act shall apply for purposes of violations of [Section 1557]."[467] However, as OCR notes in its Request for Information, "[t]hese civil rights laws may be enforced in different ways."[468] OCR

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459. 42 U.S.C. § 300gg-22 (2012).

460. *Id.*

461. *See* 42 U.S.C. § 18031(e).

462. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,823 (Feb. 27, 2015).

463. Office for Civil Rights, U.S. Dep't of Health & Human Servs., *Section 1557 of the Patient Protection and Affordable Care Act*, HHS.GOV, http://www.hhs.gov/ocr/civilrights/understanding/section1557/ (last visited Aug. 21, 2014).

464. Exec. Order No. 12,250, 45 Fed. Reg. 72,995 (Nov. 12, 1980), http://www.justice.gov/crt/about/cor/EO_12250.pdf.

465. U.S. DEP'T OF JUST., *Civil Rights Division: About the Division*, http://www.justice.gov/crt/about/ (last visited Aug. 21, 2014).

466. Letter from Emily Spitzer, Executive Director, National Health Law Program, to Leon Rodriguez, Director, Officer for Civil Rights, U.S. Dep't of Health & Human Servs. (Sept. 30, 2013), http://www.regulations.gov/#!documentDetail;D=HHS-OCR-2013-0007-0049.

467. 42 U.S.C. § 18116 (2012).

468. Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities, 78 Fed. Reg. 46,558, 46,560 (Aug. 1, 2013).

goes on to explain that "Title VI, Title IX, and Section 504 have one set of established administrative procedures for investigation of entities that receive federal financial assistance from [HHS]," while "[t]he Age Act has a separate administrative procedure that is similar, but requires mediation before an investigation."[469] OCR asks for comments on the effectiveness of the different approaches to enforcement and for ways in which they could be strengthened.[470]

Katie Keith and her colleagues argue that "ensuring that the ACA's nondiscrimination standards are met likely requires ongoing monitoring of consumer complaints, the development of new infrastructure such as tracking systems, robust grievance and appeals processes, and clarification of federal requirements."[471] They also recommend that "[i]n reevaluating essential health benefits standards for 2016, HHS should consider whether the benchmark plan approach adequately protects against discrimination."[472]

VI. CONCLUSION

When he signed the ACA into law, President Obama cited as its "core principle" that "everybody should have some basic security when it comes to their health care."[473] Basic security in health care has a financial component (access to health insurance) and a clinical component (access to appropriate health care). The ACA has made significant strides in advancing the financial goal, as millions have newly gained access to insurance. Those gaining insurance through small-group and individual coverage are entering a complex market with the conflicting goals of extending care and restraining cost. Wise decisions by consumers, market participants, and regulators can help to ensure that the balance struck between cost and care is the proper one.

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469. *Id.*

470. *Id.*

471. KEITH ET AL., *supra* note 322, at 16.

472. *Id.* At 5.

473. *Remarks by the President and Vice President at Signing of the Health Insurance Reform Bill*, WHITEHOUSE.GOV, (Mar. 23, 2010, 11:29 AM), http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill.

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