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The Sentinel Project: The ACA's Marketplace Reforms and Access to Care

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EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (“ACA”) is intended to connect Americans with affordable, medically necessary health care. The first step toward achieving that goal is insurance expansion. The ACA’s first year of insurance expansion has allowed millions of Americans to newly obtain insurance. 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”).

There is a third necessary step in fulfilling the promise of the ACA. 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 Sentinel Project of Seton Hall Law School will address this third step by assessing the market behavior of plans as consumers seek access to appropriate health care. This Report describes the history of health plans’ behavior in fulfilling their contractual obligations, the regulatory structure designed to assure the smooth functioning of the health insurance markets, and the Sentinel Project’s plan to assess the ACA’s effect on those markets.

The Sentinel Project will examine the interactions among consumers, insurers, and regulators in the individual and small group markets. With our partner, New Jersey Appleseed, we will provide advice and representation when plans deny coverage to consumers; interview health care providers, health insurers, regulators, advocates, and consumers; and review the emerging literature on health coverage disputes. We anticipate that the information we garner will raise issues in four categories of concern:

- *Contract exclusions:* Federal regulators devolved to the states much of the task of defining the essential health services that must be covered in the individual and small group markets through the recognition of state “benchmark plans.” State insurance mandates, as modified by the ACA’s requirements, set the type and extent of coverage that must be made

available to consumers. The Sentinel Project will review New Jersey plans' conformance with the blueprint set out by the State's benchmark plan to assure that required services are adequately covered. The Project also will review the extent to which the coverage design under the benchmark, as implemented, comports with the ACA.

- *Medical Necessity:* Consumers rely on their insurance to cover health services recommended by their health providers. As consumers seek care, their plans will evaluate the medical need for specific services, such as surgery, behavioral health services, habilitative care, and routine primary care. When a plan and an individual's treating professional disagree on the necessity of a particular treatment, procedures mandated by state and federal law are available for the resolution of the dispute. The Sentinel Project will assess the application of available dispute resolution processes.
- *Network Adequacy:* To keep premiums at a reasonable level, many plans have adopted narrower provider networks. In addition, some plans have adopted "tiered" structures for their provider networks, with different providers available to insureds under varying cost-sharing schedules. The narrowing and tiering of networks can be beneficial to consumers if the network design is thoughtfully undertaken in the interest of cost-containment and quality of care. Plans can violate state law and the ACA, however, if they deprive consumers of appropriate access to care, including access to a full range of qualified providers through timely appointments within a reasonable travel distance. The Sentinel Project will review plans' network policies to assess compliance with state law and the ACA.
- *Discrimination:* The ACA highlighted the need to protect consumers from discrimination in access to coverage and care. The ACA was intended to end discrimination on the basis of health history, disability, and other characteristics. Even in the context of non-discriminatory contract language, some coverage decisions involve fine distinctions that can result in discrimination against vulnerable and protected categories of insureds. The Sentinel Project will seek to determine whether plans' efforts to contain costs cross the line from prudent plan management to unlawful discrimination.

The Sentinel Project will use the information it obtains through consumer representation, interviews of stakeholders, and independent research to create a feedback loop that circulates important indications of the functioning of the insurance market. We will provide information on market behavior to insurers, consumers, regulators, providers, and advocates. Our goal is to contribute to the success of the implementation of the ACA by assisting in the smooth performance of the market for individual and small group insurance. The Sentinel Project's efforts are intended to:

- Inform insurers of emerging concerns as consumers negotiate new insurance products;
- Assist consumers as they seek to obtain and understand services covered by their health plans, and to advise and assist them as disputes with their health plans arise;
- Enhance consumer understanding of the structure and functioning of health plans in the individual and small group markets;
- Inform federal and state regulators of concerns that arise as consumers and plans respond to market and regulatory influences;
- Assess the efficacy of existing consumer protections in assuring appropriate coverage of necessary care in the reformed markets; and
- Assess the need for amendments to the regulatory structure that guides the operation of this vital market for health coverage.

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I. INTRODUCTION

A. Coverage and Care: Extending Access to Coverage under Health Reform

The Affordable Care Act (“ACA”)¹ was a signal event in the century-long efforts to reform America’s health care and financing system. American health care is dynamic and innovative, but it has long been recognized to suffer from major faults. First, tens of millions of Americans are without public or private health insurance, with almost fifty million uninsured in 2010.² In addition, Americans, whether insured or uninsured, have greater difficulties accessing appropriate health care than do residents of other wealthy nations.³ These faults point to a need to reform the health insurance system, both to enable more Americans to gain coverage, and to ensure that insurance, once obtained, allows consumers to receive the health care services they need. Access to coverage and care are intertwined, and health systems analysts have stressed that health reform should comprehensively address our health system’s faults.⁴

Coverage expansion is a centerpiece of the ACA. The expansion was intended to be fueled by changes in both the private insurance system and Medicaid. The ACA’s effect on private insurance enrollment has been substantial. 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

¹ The 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, as amended, is often referred to as the “Affordable Care Act,” or the “ACA,” and will be referred to as such herein.

²U.S. CENSUS BUREAU, HEALTH INSURANCE HISTORICAL TABLES - HIB SERIES, http://www.census.gov/hhes/www/hlthins/data/historical/HIB_tables.html (last visited July 21, 2014).

³ See Cathy Schoen *et al.*, *Access, Affordability, And Insurance Complexity Are Often Worse In The United States Compared To Ten Other Countries*, 32 HEALTH AFFAIRS 2205 (2013).

⁴ See Jonathan Oberlander, *Unfinished Journey – A Century of Health Care Reform in the United States*, 367 NEW ENG. J. MED. 585 (2012); Timothy Stoltzfus Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 42 WAKE FOREST L. REV. 537 (2006).

the exchanges.⁵ The ACA was effective in increasing access to private insurance in two key ways. First, it significantly reformed the private health insurance market inside and outside of health insurance exchanges. It permits new access to coverage, for example, by prohibiting denials of coverage based on preexisting conditions; requiring insurers to write and renew insurance for all applicants; and limiting the extent to which an insured's age can affect insurance premiums.⁶

Second, the ACA improved the affordability of coverage. It imposes caps on consumer cost sharing, including deductibles and copayments for all insureds.⁷ In addition, it provides substantial subsidies for low-income consumers. One of these subsidies reduces the cost of premiums for consumers with income below 400 percent of the federal poverty level, and is provided in the form of a tax credit.⁸ The ACA also provides a second subsidy for the lowest-income consumers in the individual and small group markets: those with incomes between 100 and 250 percent of the federal poverty level. This second form of subsidy is channeled to the person's insurer, and allows low-income consumers a reduction in their out-of-pocket costs to obtain covered care.⁹

The text of the ACA also dramatically changed the structure of Medicaid, although the uniformity of that change was undermined when the United States Supreme Court ruled that states may refuse to participate in the statute's Medicaid expansions.¹⁰ As written, the ACA swept away the archaic distinction between the "worthy poor" and "unworthy poor." Its simplified standards permitted anyone with income below 133 percent of the federal poverty level to qualify for coverage.¹¹ After the Supreme Court's decision, many states decided not to adopt the ACA's Medicaid

⁵ U.S. DEPT OF HEALTH & HUMAN SERVS., HEALTH INSURANCE MARKETPLACE: SUMMARY ENROLLMENT REPORT FOR THE INITIAL OPEN ENROLLMENT PERIOD 7 (May 1, 2014).

⁶ 42 U.S.C. §§ 300gg-1, 300gg-2, 300gg(a), 300gg-3.

⁷ 42 U.S.C. § 18022(c). This provision caps the consumer share of coverage (except for premium cost) for all non-grandfathered plans for all consumers regardless of income level. The cap is set at \$6,350 for individual coverage and \$12,700 for all other forms of coverage for 2014, with the amounts to increase in future years to reflect inflation. For 2014 only, some plans that use more than one firm to administer benefits – for example, where a firm has separate administration of pharmaceutical benefits – may apply separate out-of-pocket caps for the different benefits programs. See U.S. DEPT OF LABOR, FAQs ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART XVIII) AND MENTAL HEALTH PARITY IMPLEMENTATION (Jan. 9, 2014), available at <http://www.dol.gov/ebsa/faqs/faq-aca18.html>; Michelle Andrews, *Federal Rule Allows Higher Out-Of-Pocket Spending For One Year*, KAISER HEALTH NEWS (June 11, 2013), <http://www.kaiserhealthnews.org/Features/Insuring-Your-Health/2013/061113-Michelle-Andrews-out-of-pocket-costs.aspx>.

⁸ 26 U.S.C. § 36B.

⁹ 42 U.S.C. § 18071(c). This out-of-pocket subsidy is in addition to the general limitation on out-of-pocket costs set forth in 42 U.S.C. § 18022(c).

¹⁰ *N.F.I.B. v. Sebelius*, 567 U.S. ___, ___, 132 S. Ct. 2566, 2605-07 (2012) (holding that the Secretary of Health and Human Services may not withhold the federal share payment for a state's pre-ACA Medicaid program if the state refuses to adopt the Medicaid expansions contained in the ACA).

¹¹ 42 U.S.C. § 1396a.

expansions.¹² Nevertheless, the Centers for Medicare and Medicaid Services (“CMS”) estimated in July 2014 that Medicaid enrollment had increased by about 6.7 million persons as compared to enrollment before the ACA’s expansions became effective.¹³ This substantial increase, not surprisingly, was much greater in states participating in the expansion than in those that did not. The increase in expansion states has been estimated at approximately seventeen percent, compared with approximately three percent in refusing states.¹⁴

Access to health coverage serves the traditional insurance function of protecting consumers from financial distress or bankruptcy. Studies have shown that lack of insurance, or lack of adequate insurance, can lead to high levels of consumer debt, and that medical debt is one of the largest factors in consumer bankruptcy filings.¹⁵ In addition, health insurance status is an important indicator of health status: children and adults with health insurance tend to be healthier. Noting that “coverage matters,” the Institute of Medicine (“IOM”) has found that a “robust body of evidence demonstrates substantial health benefits of health insurance coverage.”¹⁶ Health coverage improves access to preventive care, reduces disruptions in courses of care,¹⁷ and helps to reduce racial and ethnic disparities in health access and health status.¹⁸

¹² See Families USA, *A 50-State Look at Medicaid Expansion: 2014*, <http://familiesusa.org/product/50-state-look-medicare-expansion-2014> (reporting that as of May 2014, twenty-six states and the District of Columbia had agreed to expand Medicaid, twenty states had opted not to expand, and four states were in the process of making a decision); NAT’L CONFERENCE OF STATE LEGISLATURES, *Affordable Care Act Medicaid Expansion*, available at <http://www.ncsl.org/research/health/affordable-care-act-expansion.aspx> (reporting that as of July 11, 2014, twenty-two states and the District of Columbia had agreed to expand Medicaid, twenty-two states had opted not to expand, and six states were “[c]urrently implementing or exploring expansion alternatives”).

¹³ CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., *MEDICAID AND CHIP: MAY 2014 MONTHLY APPLICATIONS, ELIGIBILITY DETERMINATIONS, AND ENROLLMENT REPORT 3* (July 11, 2014), available at <http://www.medicare.gov/AffordableCareAct/Medicaid-Moving-Forward-2014/medicaid-moving-forward-2014.html>.

¹⁴ *Id.*

¹⁵ See generally David U. Himmulstein *et al.*, *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741 (2007); Melissa B. Jacoby *et al.*, *Rethinking the Debates over Health Care Financing: Evidence from the Bankruptcy Courts*, 76 N.Y.U. L. REV. 375 (2001).

¹⁶ INSTITUTE OF MEDICINE, *AMERICA’S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE* 5 (The National Academies Press, 2009).

¹⁷ See Jennifer E. DeVoe *et al.*, *Receipt of Preventive Care Among Adults: Insurance Status and Usual Source of Care*, 93 AM. J. PUB. HEALTH 786 (2003).

¹⁸ See Marsha Lillie-Blanton & Catherine Hoffman, *The Role Of Health Insurance Coverage In Reducing Racial/Ethnic Disparities in Health Care*, 24 HEALTH AFFAIRS 398 (2005).

B. The Content of Coverage: Insurance Plan Design and Reform

Health insurance in the United States has been more complex, variable, and opaque than coverage in other countries.¹⁹ The variability of coverage design has been a function of the freedom states have enjoyed to set their own standards for health insurance, and the competitive nature of American health insurance markets, each of which fostered a variety of coverages with differing plan designs.²⁰ Some of those designs have omitted services that are highly desirable to some consumers. Mental health services, home care, and even preventive services can be central to the well-being of some consumers. Comprehensive coverage, however, has the effect of increasing the cost of the insurance product for all consumers – those who need or desire particular services, and those who do not; less robust coverage, on the other hand, leaves some consumers without potentially important coverage.²¹

States have responded variously to the choice to mandate comprehensive coverage or permit insurers to offer less robust coverage.²² Permitting insurers to exclude coverage of important forms of treatment allows for lower cost coverage. The treatments excluded from coverage, however, are essential to meet the health care needs of some consumers. Permitting both more and less comprehensive coverage leads to distortions in the insurance market and can ultimately harm high-needs consumers. It allows market distortion through adverse selection, as high-risk consumers would tend to favor more comprehensive coverage.²³ The skewing of the risk pool would increase premiums for comprehensive plans to a level beyond the reach of many consumers, including those in need of the comprehensive coverage.²⁴ Those who need the services only covered in comprehensive plans would, in effect, be penalized because they have, through no fault of their own, high cost conditions.²⁵

In response to these concerns, states developed a range of health insurance mandate laws.²⁶ These laws failed to achieve uniformity in the insurance market, however. The mandate laws were state-specific, and therefore subjected purchasers

¹⁹ See Cathy Schoen *et al.*, *How Health Insurance Design Affects Access To Care And Costs, By Income, In Eleven Countries*, 29:12 HEALTH AFFAIRS 1, 6-7 (2010).

²⁰ See Amy Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 147-48 (2012).

²¹ See *id.* at 147-150.

²² See *id.* at 143.

²³ See *id.* at 148.

²⁴ See *id.* at 148-49.

²⁵ See *id.* at 149.

²⁶ In addition, state-level regulation was believed to be particularly susceptible to special pleading from self-interested health providers able to influence state legislatures and obtain insurance mandates that serve little social utility. *Id.* at 150-51.

and insurers to different standards from state to state.²⁷ In addition, many consumers obtain their health coverage from employers who do not purchase state-regulated insurance. These employers self-fund their employees' health care rather than purchase insurance and are therefore exempt from state insurance regulation, including regulations mandating particular health benefits.²⁸

With the passage of the ACA, Congress entered the field of regulating plan design. It set out “essential health benefits” (“EHBs”) applicable to most plans offered in the individual and small group markets.²⁹ The EHB provision embodies a policy to protect consumers in those markets who need services that might not be available in insurance products regulated by the markets or the states:

At the core of the EHB requirement is the conviction that the content of insurance coverage matters. It is fundamental that a person's ownership of an insurance card is only as valuable as the services to which that card creates an entitlement. . . . With the EHB requirement, Congress . . . requir[ed] that most individual and small group health insurance uniformly cover services comprising a comprehensive menu of health care. That is, Congress determined that health insurance, to be worthy of the name, should cover each of the ten categories of essential health benefits.³⁰

The EHB provision covers, for example, “[m]ental health and substance use disorder services, including behavioral health treatment,” and habilitative services,³¹ services that were often not fully covered prior to the ACA's enactment.

C. Plans in Operation: Assessing the Market Behavior of Plans

The ACA is designed to render health insurance more accessible so that Americans can obtain appropriate health care services. The statute has been successful in expanding coverage, including coverage in the small group and individual markets in which EHB requirements apply. EHB requirements, in turn, are intended to supplement the coverage requirements in state law to ensure that

²⁷ CHERYL ULMER *ET AL.*, ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST, at 71 (IOM Oct. 2011), <http://www.iom.edu/Reports/2011/Essential-Health-Benefits-Balancing-Coverage-and-Cost.aspx>.

²⁸ Monahan, *supra* note 20, at 146-47.

²⁹ 42 U.S.C. § 18022. For a discussion of which health plans in the commercial market are subject to the ACA's EHB requirements, *see* KATE GREENWOOD *ET AL.*, SETON HALL UNIVERSITY SCHOOL OF LAW CENTER FOR HEALTH & PHARMACEUTICAL LAW & POLICY, IMPLEMENTING THE ESSENTIAL HEALTH BENEFITS REQUIREMENT IN NEW JERSEY: DECISION POINTS AND POLICY ISSUES 1-2 & n.1-5 (Aug. 2012), <http://law.shu.edu/ProgramsCenters/HealthTechIP/HealthCenter/upload/implementing-essential-health-benefits-requirement-9540.pdf>.

³⁰ GREENWOOD *ET AL.*, *supra* note 29, at iii

³¹ 42 U.S.C. § 18022(b)(1)(E) and (G).

the beneficiaries of most individual and small group plans receive coverage that is comprehensive and responsive to most peoples' health care needs.³²

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 expanded health insurance markets are built on the superstructure of the state-regulated, market-driven health insurance system that predated the passage of the ACA. Like that previous health insurance system, health insurers selling plans in the individual and small group markets will face economic incentives that run counter to the spirit of the ACA. Whether consumers fare well or poorly in the expanded insurance markets will depend on the behavior of those individual and small group plans.

The Sentinel Project of Seton Hall Law School will assess the market behavior of New Jersey health plans offered in the individual and small group markets. All of those plans are subject to federal and state regulations that are intended to regularize the provision of coverage and assure the availability of medically necessary services in a timely fashion, reasonably accessible to the consumer, without the taint of unfair discrimination.

We will gather information about plan behavior in several ways. Law students from Seton Hall Law School, working with our partner, New Jersey Appleseed, will provide counseling and representation to individual consumers covered by individual and small group insurance who are contesting denials of care. We will learn from these encounters with individual consumers the nature of the disputes, and whether their experiences suggest broader issues for the provision of insurance in this market. In addition, we will discuss coverage issues with stakeholders in New Jersey, including insurers offering health plans in the individual and small group markets; health care providers who care for insureds and deal with the plans in negotiating coverage for care on their patients' behalf; federal and state regulators; and social service and advocacy groups actively engaged with consumers in these markets. We will interview these stakeholders to gain insight into the development of these insurance markets. We will engage in research to learn of developments in other states on these issues, and perform literature reviews to engage with other academics on health reform implementation.

The essential function of the Project is to provide a feedback loop to foster understanding about the extent to which the implementation of the reformed

³² See GREENWOOD *ET AL.*, *supra* note 29, at iii. EHB requirements also apply to some Medicaid expansion populations. See CTR. FOR MEDICAID AND CHIP SERVICES., Dear Medicaid Director Letter SMDL # 12-003, ACA #21, at 2 (Nov. 20, 2012), available at <http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-12-003.pdf>.

individual and small group markets is connecting insureds with medically necessary health care. We hope to provide this information to consumers and the stakeholders described above, and to provide analysis of the indicators of the successes and failures in that implementation process. We hope to provide helpful information to plans and regulators as the system for oversight of plans evolves, and to provide information to consumers and advocates as future enrollment periods allow consumers to make choices among individual and small group plans. Finally, we will analyze the effect of federal regulations implementing the EHB provisions of the ACA, as the federal government considers modifications to those regulations.

In the following pages, we describe four areas of concern that may arise during our activities. First, we describe 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 the regulatory structure serves the spirit of the ACA, and whether regulatory adjustments are in order.

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

Third, we address network adequacy. It is an appropriate 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 practices can be beneficial or harmful to consumers, depending on the thoughtfulness of the network formation policy of each plan. We will assess the networks created.

Finally, we address 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. We will assess plan behavior to assess the presence of discrimination.

II. EXPLICIT EXCLUSIONS FROM COVERAGE AND REQUIRED 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 means by which insurers have attempted to reduce uncertainty in determining coverage has been to explicitly exclude some services from coverage in the insurance contract.³³ In some cases, the categories of excluded coverage can be quite broad, such as those excluding “experimental” services.³⁴ The intent of the exclusion is clear – to clarify the metes and bounds of the insurance contract at least to the extent that treatment must be non-experimental to qualify for coverage. Determining if a once-experimental treatment has become medically accepted requires professional assessment and expert judgment, however.³⁵

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.³⁶ These exclusions do not suffer from the indeterminacy problem often attendant to exclusions for experimental treatments. Instead, while they provide clarity, these exclusions 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.³⁷ In some cases, however, it is contestable whether cosmetic surgery is properly covered. One clear example of such a case surrounds insurers’ decisions to deny coverage for reconstructive breast surgery following a mastectomy. Such surgery is clearly “cosmetic,” and the exclusion does not therefore suffer from claims of ambiguity as do some denials for experimental treatment. Instead, the exclusion itself invites the higher-order objection that insurers ought to include reconstructive surgery following mastectomy for public policy reasons.

Regulators have responded to contract exclusions by requiring coverage of certain health benefits in the name of maintaining consumer access to appropriate healthcare. The following Subsections describe in more detail the use of federal and state mandates, culminating in the inclusion of required essential health benefits in

³³ See Monahan, *supra* note 20, at 132.

³⁴ 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).

³⁵ Sage, *supra* note 34, at 603-04.

³⁶ See Monahan, *supra* note 20, at 132; see also Mark A. Hall, *State Regulation of Medical Necessity: The Case of Weight-Reduction Surgery*, 53 DUKE L. J. 653 (2003).

³⁷ See Monahan, *supra* note 20, at 132.

the ACA. A recurring theme with each mandate is the balance that regulators must strike between improving access to care and keeping health insurance affordable.³⁸

A. Federal and New Jersey Efforts to Regulate Contract Exclusions prior to the Affordable Care Act

One tool regulators have to limit insurers' exclusion of coverage for certain categories of care in insurance contracts, and thus to ensure adequate coverage, is health insurance mandates. Mandates tend to take three general forms: service or benefit mandates, which require coverage of specific health benefits, such as mammography and prostate cancer screening; provider mandates, which require coverage of particular providers like chiropractors, if coverage is offered for another type of provider, such as physicians; and coverage mandates, which require coverage of identifiable groups such as adopted children, newborns, and domestic partners.³⁹ 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 protect coverage for specific health care services. In 1996, for example, Congress passed the Newborns' and Mothers' Health Protection Act, 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.⁴⁰ After substantial public debate on the policy reasons for and against precluding coverage, Congress also acted in 1998 to amend

³⁸ See generally Amanda Cassidy, *Essential Health Benefits. States have determined the minimum set of benefits to be included in individual and small-group insurance plans. What's next?*, at 1, HEALTH AFFAIRS (May 2, 2013), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_91.pdf (“Determining which benefits should be required in a health plan is a balancing act between comprehensiveness and cost; the more inclusive the package, the higher the cost.”); 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 (last visited Aug. 5, 2014) (“Patient advocates claim that mandates help to ensure adequate health insurance protection while others (especially health insurance companies) complain that mandates increase the cost of healthcare and health insurance.”).

³⁹ See Tracey A. LaPierre *et al.*, *Estimating the Impact of State Health Insurance Mandates on Premium Costs in the Individual Market*, JOURNAL OF INSURANCE REGULATION, at 6-7 (Mar. 1, 2009), available at <http://eds.a.ebscohost.com/ehost/pdfviewer/pdfviewer?sid=92652467-8e3c-4a61-bb72-00e4fbd9911%40sessionmgr4003&vid=0&hid=4205>.

⁴⁰ See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUMAN SERVS., *Newborns' and Mothers' Health Protection Act (NMHPA)*, http://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/nmhpfa_factsheet.html (last visited Aug. 5, 2014).

the Employee Retirement Income Security Act of 1974 (“ERISA”)⁴¹ to mandate coverage for post-mastectomy breast reconstruction.⁴²

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.⁴³ 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.⁴⁴ 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.⁴⁵ Rhode Island led the states with sixty-nine mandated benefits, whereas Idaho had the least with thirteen.⁴⁶ But 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 and do not require plans to include these services in a plan unless a consumer chooses to purchase that coverage.⁴⁷ A 2007 study that excluded offer mandates found an average of eighteen mandates per state, noting a high of

⁴¹ Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (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.).

⁴² See Women’s Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185(b) (amending ERISA to require that group plans cover reconstructive breast surgery following mastectomy). See Cristine Nardi, *When Health Insurers Deny Coverage For Breast Reconstructive Surgery: Gender Meets Disability*, 1997 WISC. L. REV. 777.

⁴³ Note that 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 39, at 6. In one instance, states do have the authority to mandate coverage. That exception is Multiple Employer Welfare Arrangements, or “MEWAs,” which are small employers’ vehicles for aggregating contributions toward employee health benefits without purchasing state-regulated insurance. Through MEWAs, small employers band together to self-fund health coverage. See U.S. Dep’t of Labor, *Fact Sheet: MEWA Enforcement*, available at <http://www.dol.gov/ebsa/newsroom/fsMEWAenforcement.html>. Because MEWA coverage is self-funded, and not insured, it historically escaped state regulation through ERISA preemption. In 1983, however, Congress amended ERISA to permit states to regulate MEWAs broadly through insurance laws. See 29 U.S.C. § 1144((b)(6)(A)(ii); see also U.S. Dep’t of Labor, *Multiple Employer Welfare Arrangements under the Employee Retirement Income Security Act (ERISA): A Guide to Federal and State Regulation* (Revised Aug. 2013), available at <http://www.dol.gov/ebsa/pdf/mwguide.pdf>.

⁴⁴ See *id.* at 4, 6.

⁴⁵ See COUNCIL ON AFFORDABLE HEALTH INSURANCE, *CAHI Identifies 2,271 State Health Insurance Mandates* (Apr. 9, 2013), <http://www.cahi.org/article.asp?id=1115> (last visited Aug. 5, 2014); Victoria Craig Bunce, COUNCIL ON AFFORDABLE HEALTH INSURANCE, *Health Insurance Mandates in the States 2012: Executive Summary*, at 2 (2013), available at http://www.cahi.org/cahi_contents/resources/pdf/Mandatesinthestates2012Execsumm.pdf.

⁴⁶ See COUNCIL ON AFFORDABLE HEALTH INSURANCE, *supra* note 45.

⁴⁷ LaPierre *et al.*, *supra* note 39, at 6; ULMER *ET AL.*, *supra* note 27, at 71 n.21.

thirty-five in California and a low of two in Idaho.⁴⁸ The National Conference of State Legislatures reports that nationally there currently are more than 1,900 state health insurance mandates.⁴⁹

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 seventy-nine unique benefit mandates.⁵⁰ 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).⁵¹ 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.⁵²

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.⁵³ 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.”⁵⁴

The 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.”⁵⁵ 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, and counseling were associated with lower premiums, and there was no correlation between the number of mandates a state enacted and premium levels in that state.⁵⁶

⁴⁸ See ULMER *ET AL.*, *supra* note 27, at 71.

⁴⁹ See NAT'L CONFERENCE OF STATE LEGISLATURES, *State Health Insurance Mandates and the ACA Essential Benefits Provisions* (updated June 2014), <http://www.ncsl.org/research/health/state-ins-mandates-and-aca-essential-benefits.aspx> (last visited Aug. 5, 2014).

⁵⁰ See LaPierre *et al.*, *supra* note 39, at 6.

⁵¹ See COUNCIL ON AFFORDABLE HEALTH INSURANCE, *supra* note 45.

⁵² See *id.*

⁵³ See ULMER *ET AL.*, *supra* note 27, at 72.

⁵⁴ COUNCIL ON AFFORDABLE HEALTH INSURANCE, *supra* note 45.

⁵⁵ ULMER *ET AL.*, *supra* note 27, at 72.

⁵⁶ See LaPierre *et al.*, *supra* note 39, at 4. 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 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.⁵⁷ Mandates, then, can help achieve health policy goals and can correct market failures.⁵⁸

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.”⁵⁹ Although the majority of states, including New Jersey,⁶⁰ require mandate benefit studies before new mandates can be adopted,⁶¹ few states “require prospective, expert analysis of evidence for a mandate before it can be voted on by the legislature.”⁶² 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.”⁶³

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.⁶⁴ 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”⁶⁵

A chart compiled by CMS summarizes New Jersey’s required benefits, including the markets to which they apply.⁶⁶ Infertility treatment, for example, is only required in large group plans that provide pregnancy-related benefits.⁶⁷ Individual and group plans must provide up to sixty home health care visits per year and alcohol treatment, but health maintenance organizations (“HMOs”) are

⁵⁷ See Bihari, *supra* note 38.

⁵⁸ See ULMER *ET AL.*, *supra* note 27, at 72.

⁵⁹ *Id.*

⁶⁰ See N.J. STAT. ANN. § 17B:27D-1 et seq. (creating the Mandated Health Benefits Advisory Commission “to conduct a review of proposed mandated health benefits by an expert body to provide the Legislature with adequate and independent documentation defining the social and financial impact and medical efficacy of the proposed mandate”).

⁶¹ See LaPierre *et al.*, *supra* note 39, at 4.

⁶² See ULMER *ET AL.*, *supra* note 27, at 72.

⁶³ *Id.*

⁶⁴ LaPierre *et al.*, *supra* note 39, at 4.

⁶⁵ *Id.* at 33.

⁶⁶ See CTRS. FOR MEDICARE & MEDICAID SERVCs., NEW JERSEY-STATE REQUIRED BENEFITS, <https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/nj-state-required-benefits.pdf> (last visited Aug. 5, 2014).

⁶⁷ See *id.*

excluded from these requirements.⁶⁸ Individual and large group plans are required to provide health promotion and diabetes treatment, but small group plans are not. Individual, small group, and large group plans must provide a number of other benefits, including minimum mastectomy and maternity stays, orthotic and prosthetic appliances, hearing aids for patients fifteen or younger, colorectal cancer screening, female contraceptives, treatments for autism and other developmental disabilities, treatment of domestic violence injuries, treatment for inherited metabolic diseases, and coverage for biologically-based mental illness, among others.⁶⁹

As part of the State's comprehensive health insurance reforms in 1992, New Jersey created the Individual Health Coverage ("IHC") and Small Employer Health Benefits ("SEH") Program Boards of Directors to establish the coverage, benefit levels, and contract forms for individual and small group health benefits plans.⁷⁰ The IHC and SEH Program Boards have created a number of standard health benefit plans that provide the following comprehensive inpatient and outpatient hospital and medical coverage for plan year 2014: office visits, hospital care, prenatal and maternity care, immunizations and well-child care, screenings, including mammograms, pap smears and prostate examinations, x-ray and laboratory services, mental illness services, substance abuse services, therapy services, prescription drugs, and pediatric dental and vision services.⁷¹ The plans that may be sold in each market are standard in that they cover the same health care services, supplies, and medical conditions, as determined by the Boards, but they differ from each other with respect to cost-sharing levels and the means by which members may access out-of-network providers, and the extent to which out-of-network services are covered.⁷²

⁶⁸ *See id.*

⁶⁹ *Id.*

⁷⁰ *See* N.J. STAT. ANN. § 17B:27A-10(f)(3); 17B:27A-11(d); 17B:27A-28; N.J.A.C. §§ 11:20-2.10; 11:20-3.1 & Appendix Exhs. A & B; 11:21-3.1 & Appendix Exhs. F, G, V, W, Y, HH, II; N.J. DEP'T OF BANKING & INS., NJ INDIVIDUAL HEALTH COVERAGE PROGRAM BUYER'S GUIDE: INTRODUCTION, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcguide/introduction.html (last visited Aug. 6, 2014) [hereinafter "DOBI, IHC BUYER'S GUIDE: INTRODUCTION"].

⁷¹ *See* N.J. DEP'T OF BANKING & INS., NJ INDIVIDUAL HEALTH COVERAGE PROGRAM BUYER'S GUIDE: THE COVERAGE, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcguide/coverage.html (last visited Aug. 6, 2014) [hereinafter "DOBI, IHC BUYER'S GUIDE: THE COVERAGE"]; N.J. DEP'T OF BANKING & INS., NJ SMALL EMPLOYER HEALTH BENEFITS PROGRAM BUYER'S GUIDE: THE STANDARD SMALL EMPLOYER HEALTH BENEFITS PLANS, http://www.state.nj.us/dobi/division_insurance/ihcseh/sehguide/standardbenefits.html (last visited Aug. 6, 2014) [hereinafter "DOBI, SEH BUYER'S GUIDE: THE STANDARD SMALL EMPLOYER HEALTH BENEFITS PLANS"].

⁷² *See* DOBI, IHC BUYER'S GUIDE: THE COVERAGE, *supra* note 71; DOBI, SEH BUYER'S GUIDE: THE STANDARD SMALL EMPLOYER HEALTH BENEFITS PLANS, *supra* note 71. The standard contracts are available on DOBI's website. *See* N.J. DEP'T OF BANKING & INS., IHC PROGRAM FORMS, http://www.state.nj.us/dobi/division_insurance/ihcseh/ihcforms.html (last visited Aug. 6, 2014); N.J. DEP'T OF BANKING & INS., SEH PROGRAM FORMS, http://www.state.nj.us/dobi/division_insurance/ihcseh/sehforms.html (last visited Aug. 6, 2014).

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-grandfathered⁷³ 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.⁷⁴ 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. What is deemed a preventive health service will evolve as evidence becomes available,⁷⁵ but currently a variety of services for adults,⁷⁶ women,⁷⁷ and children⁷⁸ 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. 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," and nearly 2.3 million of these newly insured are in New Jersey.⁷⁹

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, equal to the scope of

⁷³ 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).

⁷⁴ See 42 U.S.C. § 300gg-13.

⁷⁵ See, e.g., Phil Galewitz, *For High-Risk Women, Some Breast Cancer Drugs To Be Free*, CAPSULES: THE KHN BLOG (Jan. 9, 2014 3:14 PM), available at <http://capsules.kaiserhealthnews.org/index.php/2014/01/breast-cancer-drugs-to-be-free-for-high-risk-women/> (reporting that beginning in September 2015, certain prescriptions shown to help prevent breast cancer, such as tamoxifen and raloxifene, will be provided without a copay to women at increased risk for the disease based on September 2013 recommendations from the U.S. Preventive Services Task Force).

⁷⁶ See HEALTHCARE.GOV, *Preventive care benefits: Preventive health services for adults*, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/adults> (last visited Aug. 6, 2014).

⁷⁷ See HEALTHCARE.GOV, *Preventive care benefits: Preventive health services for women*, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/women> (last visited Aug. 6, 2014).

⁷⁸ See HEALTHCARE.GOV, *Preventive care benefits: Preventive health services for children*, <https://www.healthcare.gov/what-are-my-preventive-care-benefits/children> (last visited Aug. 6, 2014).

⁷⁹ AMY BURKE & ADELLE SIMMONS, OFFICE OF THE ASST. SEC'Y FOR PLANNING & EVAL., DEP'T OF HEALTH & HUMAN SERVS., INCREASED COVERAGE OF PREVENTIVE SERVICES WITH ZERO COST SHARING UNDER THE AFFORDABLE CARE ACT 2, 4 (June 27, 2014), available at http://aspe.hhs.gov/health/reports/2014/PreventiveServices/ib_PreventiveServices.pdf.

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, including oral and vision care.⁸⁰

By itemizing EHB categories, Congress was aiming to ensure that individual and small group plans would offer uniform, comprehensive coverage. 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.⁸¹ For nearly two years following 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.⁸² The expectation was that HHS would establish a national standard for EHB, as suggested by the IOM.⁸³

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. States have the opportunity to select a benchmark plan from a menu of existing health care plans identified by HHS, namely, the largest plan by enrollment in any of the State’s three largest small group insurance products; any of the largest three State employee health benefit plans by enrollment; any of the three national Federal Employees Health Benefits Program (“FEHBP”) plan options by enrollment; or the largest insured commercial non-Medicaid HMOs operating in the State.⁸⁴ 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.”⁸⁵ 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.⁸⁶ 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

⁸⁰ See 42 U.S.C. §§ 300gg-6(a), 18022. 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).

⁸¹ See 42 U.S.C. § 18022(b); see generally GREENWOOD ET AL., *supra* note 29.

⁸² See GREENWOOD ET AL., *supra* note 29, at 5-6.

⁸³ See ULMER ET AL., *supra* note 27, at 6.

⁸⁴ See 45 C.F.R. § 156.100(a).

⁸⁵ *Id.* § 156.100(c).

⁸⁶ See *id.* § 156.110(b); see also *id.* § 156.110(c) (regarding supplementing default benchmark plans).

limits.”⁸⁷ 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.⁸⁸

New Jersey selected the largest small group HMO plan to serve as its benchmark, Horizon HMO Access HSA Compatible,⁸⁹ which already had to comply with the State’s small group standard plan prior to the effective date of the EHB requirement. The IHC and SEH Boards made adjustments to the individual and small group standard contracts to ensure they include all ten essential health benefits,⁹⁰ supplementing the benchmark with the pediatric oral care coverage provided by NJ FamilyCare (CHIP) and the pediatric vision care coverage provided by the Federal Employees Dental Vision Program (“FEDVIP”).⁹¹

C. Next Steps

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 plans pre-ACA were covering services in many of the EHB

⁸⁷ CTRS. FOR MEDICARE & MEDICAID SERVS., DEP’T OF HEALTH & HUMAN SERVS., FREQUENTLY ASKED QUESTIONS ON ESSENTIAL HEALTH BENEFITS BULLETIN, at 5 (Feb. 17, 2012), <http://cciio.cms.gov/resources/files/Files2/02172012/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).

⁸⁸ See 45 C.F.R. § 156.115(a)(4); EHB FAQ, *supra* note 87, 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. 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” 45 C.F.R. § 156.115(d).

Prescription drug benefits have received special attention. The Secretary has promulgated regulations specifying what formulary is adequate for health plans required to comply with EHB requirements. They must include in their formularies the “greater of . . . [o]ne drug in every United States Pharmacopeia (USP) category and class; or . . . [t]he same number of prescription drugs in each category and class in the EHB-benchmark plan.” 45 C.F.R. § 156.122(a)(1). The health plan also is required to “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).

⁸⁹ See CTRS. FOR MEDICARE & MEDICAID SERVS., *New Jersey EHB Benchmark Plan*, <http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/new-jersey-ehb-benchmark-plan.pdf> (last visited Aug. 8, 2014) [hereinafter “CMS, *N.J. Benchmark*”]; *Digging in to Benchmark Plan Details*, STATEREFOR(U)M.ORG, <https://www.statereforum.org/analyses/state-progress-on-essential-health-benefits#sthash.qyZpFsOO.dpuf>.

⁹⁰ See Notes of Interviews with N.J. Dep’t of Banking & Ins. Staff (on file with authors); *Final Minutes of the Annual Meeting of the New Jersey Individual Health Coverage Program Board at the Offices of the New Jersey Department of Banking and Insurance* (Jan. 8, 2013), at 4-5, available at http://www.state.nj.us/dobi/division_insurance/ihcseh/minutes/ihc130108.pdf; N.J. DEP’T OF BANKING & INS., SMALL EMPLOYER HEALTH BENEFITS PROGRAM BOARD, SMALL EMPLOYER HEALTH BENEFITS PROGRAM RULES AND STANDARD PLANS, PRN 2013- (Dec. 10, 2013), available at http://www.state.nj.us/dobi/division_insurance/ihcseh/rules/sehproposal131127/proposal.pdf.

⁹¹ See CMS, *N.J. Benchmark*, *supra* note 89; STATEREFOR(U)M, *supra* note 89.

categories. 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 thus may pose implementation challenges: mental health and substance use disorder services, pediatric oral and vision services, and habilitative services.⁹²

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.⁹³ HHS found that it was unclear from summary plan documents whether plans cover behavioral health treatment (“BHT”), which is part of EHB.⁹⁴ It also found that, in general, BHT for autism tended to be covered only when there was a corresponding state mandate.⁹⁵ As discussed in more detail in Section V(D) 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”).⁹⁶ 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.⁹⁷

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”).⁹⁸ 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.⁹⁹ When a

⁹² See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN, at 5-6 (Dec. 16, 2011), http://cciio.cms.gov/resources/files/Files2/12162011/essential_health_benefits_bulletin.pdf [hereinafter “EHB BULLETIN”].

⁹³ See *id.*

⁹⁴ See *id.*

⁹⁵ See *id.*

⁹⁶ See 45 C.F.R. § 156.115(a)(3) (citing *id.* § 146.136).

⁹⁷ See Section IV, *infra*.

⁹⁸ See 42 U.S.C. § 18031(d)(2)(B)(ii); 45 C.F.R. § 155.1065(b); see generally 42 U.S.C. § 18021 (defining qualified health plans).

⁹⁹ See CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., *2015 Letter to Issuers in the Federally-facilitated Marketplaces*, at 31-32 (Mar. 14, 2014), available at <http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf> [hereinafter “CMS, 2015 Letter to Issuers”]; CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEPT OF HEALTH & HUMAN SERVS., *Affordable Exchanges Guidance: Letter to Issuers on Federally-facilitated and State Partnership Exchanges*, at 29-33 (Apr. 5, 2013), available at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf [hereinafter “CMS, 2013 Letter to

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.¹⁰⁰ 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, exchange consumers may forego purchasing the stand-alone plans that provide pediatric coverage,¹⁰¹ 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,¹⁰² these out of pocket cost-sharing amounts are not included in calculations for cost-sharing subsidies,¹⁰³ 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.¹⁰⁴ It is not surprising, then, that a study by the American Dental Association found that only thirty-four 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.¹⁰⁵ 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.¹⁰⁶

HHS noted that of the ten EHB categories, the least is known about plan coverage of habilitative care. Prior to the ACA, few plans identified services using

Issuers”]; ANDREW SNYDER *ET AL.*, NATIONAL ACADEMY FOR STATE HEALTH POLICY, IMPROVING INTEGRATION OF DENTAL HEALTH BENEFITS IN HEALTH INSURANCE MARKETPLACES 11 (Apr. 2014), available at http://www.nashp.org/sites/default/files/improving_integration_of_dental_health_benefits_in_health_insurance_marketplaces_0.pdf.

¹⁰⁰ 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 (“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. Such bracketed text must be included in plans otherwise issued in New Jersey unless a carrier is reasonably assured that an individual has obtained such pediatric dental coverage through a marketplace-certified stand-alone dental plan.”).

¹⁰¹ See *Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Final Rule*, 78 Fed. Reg. 12834, 12853 (Feb. 25, 2013), available at <http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf> [hereinafter “*EHB Final Rule Preamble*”].

¹⁰² See 45 C.F.R. § 156.150(a).

¹⁰³ See 42 U.S.C. § 18071(c)(5); 45 C.F.R. § 156.440(b); SNYDER *ET AL.*, *supra* note 99, at 5.

¹⁰⁴ SNYDER *ET AL.*, *supra* note 99, at 15.

¹⁰⁵ See Marissa Evans, *Many kids fall through gaps in dental care*, USA TODAY (May 17, 2014 8 AM EDT), available at <http://www.usatoday.com/story/news/nation/2014/05/17/kids-dental-plans/9098439/>.

¹⁰⁶ See, e.g., Joe Tuschner, *Time for a Dental Check Up*, GEORGETOWN CENTER ON HEALTH INSURANCE REFORMS BLOG (Mar. 14, 2014), available at <http://ccf.georgetown.edu/all/time-for-a-dental-check-up/>.

this label, and there is no universally accepted definition of these services.¹⁰⁷ While HHS wrestles with how to define habilitative services, it has implemented a transitional policy that lets states determine what services to include in their benchmark plans for this EHB category.¹⁰⁸ In states that do not define habilitative services, issuers have a choice among two options.¹⁰⁹ Plans may 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.”¹¹⁰ Alternatively, issuers may define what constitutes habilitative services and report the definition they employ to HHS, which will consider the matter.¹¹¹ It will be important to assess whether these different policy approaches impact the scope of services covered and whether HHS should adopt a clear definition to guide and standardize coverage of habilitative services in the future.

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.¹¹² 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.”¹¹³ When it finalized the rules, HHS required issuers to cover “at least the greater of: (i) One drug in every United States Pharmacopeia (USP) category and class; or (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan.”¹¹⁴ It is critical to evaluate if this policy provides consumers with access to medically appropriate prescription drug coverage as Congress intended.¹¹⁵

Although the ACA prohibits annual and lifetime dollar limits on EHB,¹¹⁶ HHS is permitting such limits to “be converted to actuarially equivalent treatment

¹⁰⁷ See EHB BULLETIN, *supra* note 92, at 6.

¹⁰⁸ *EHB Final Rule Preamble*, *supra* note 101, at 12843, 12844; 45 C.F.R. § 156.110(f).

¹⁰⁹ See *EHB Final Rule Preamble*, *supra* note 101, at 12843-44.

¹¹⁰ 45 C.F.R. § 156.115(a)(5).

¹¹¹ *Id.* § 156.115(a)(5).

¹¹² EHB BULLETIN, *supra* note 92, at 12-13.

¹¹³ Kenneth Thorpe, *Determining “Essential” Health Benefits*, THE HILL’S CONGRESS BLOG (June 20, 2012 1:46 P.M. EST); see also COLORADO CONSUMER HEALTH INITIATIVE, *Comments to the Dep’t of Health & Human Servs. re: 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), available at <http://www.regulations.gov/#!documentDetail;D=CMS-2012-0071-0036> (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”).

¹¹⁴ See 45 C.F.R. § 155.1.22(a)(1).

¹¹⁵ See, e.g., Section V(E), *infra* (discussing prescription drug tiering).

¹¹⁶ See 45 C.F.R. § 147.126.

or service limits.”¹¹⁷ 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.”¹¹⁸ Tim Jost similarly has warned that “[t]his will substantially undermine the dollar limit prohibition.”¹¹⁹ 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.¹²⁰ 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 and 2015 pursuant to which the agency will not consider a state-required benefit that was enacted on or before December 31, 2011 to be in addition to the essential health benefits.¹²¹ It will be important for New Jersey to monitor HHS’s decision because if it alters this policy, New Jersey 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 100 percent. 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.¹²² 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-

¹¹⁷ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTRS. FOR MEDICARE & MEDICAID STUDIES, ADDITIONAL INFORMATION ON PROPOSED STATE ESSENTIAL HEALTH BENEFITS BENCHMARK PLANS, <http://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html> (last visited Aug. 8, 2014); *see also* EHB FAQ, *supra* note 87, at 4.

¹¹⁸ Letter from Robert W. Block, President, American Academy of Pediatrics, to Marilyn A. Tavenner, Acting Administrator, Centers for Medicare & Medicaid Services (July 5, 2012) (on file with authors).

¹¹⁹ 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/>.

¹²⁰ *See* 42 U.S.C. § 18031(d)(3)(B).

¹²¹ *See* 45 C.F.R. § 155.170(a)(2); *EHB Final Rule Preamble*, *supra* note 101, at 12838.

¹²² *See* Melinda Beck, *Discord Over What to Pay the Doctor*, WALL STREET JOURNAL ONLINE (Apr. 13, 2014, 7:33 p.m. ET), *available at* <http://online.wsj.com/news/articles/SB10001424052702304058204579495552393406252>.

sharing.¹²³ 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.¹²⁴ 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.

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%), cosmetic surgery (92%), adult dental services (89%), weight loss programs (88%), acupuncture (84%), routine foot care (72%), infertility treatment (67%), private nursing (67%), adult eye exams (61%), and weight loss surgery (59%).¹²⁵ Interestingly, eighty 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.¹²⁶ Although most excluded services continue to be excluded post-EHB, the study noted that weight loss programs dropped from being excluded by ninety-three percent of the plans in 2013 to eighty-eight percent in 2014; weight loss surgery had been excluded by ninety percent and now was excluded by only fifty-nine percent of plans; and infertility treatment went from being excluded by ninety-four percent down to two-thirds of health plans.¹²⁷ 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.

Given the plethora of questions regarding preventive health and EHB implementation, systemic monitoring of the ACA’s rollout is critical.¹²⁸ The internal and external appeals procedures discussed in Section III(B) below are not available

¹²³ See THE CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, CTNS. FOR MEDICARE & MEDICAID SERVCES., *Affordable Care Act Implementation FAQs - Set 12, Ques. 5*, available at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html#Coverage_of_Preventive_Services.

¹²⁴ See KAREN POLLITZ ET AL., COVERAGE OF COLONOSCOPIES UNDER THE AFFORDABLE CARE ACT’S PREVENTION BENEFIT 3 (Sept. 2012), available at <http://kaiserfamilyfoundation.files.wordpress.com/2012/08/8351-coverage-of-colonosopies-under-the-affordable-care-act.pdf>.

¹²⁵ See *Top 10 Healthcare Services Excluded Under Obamacare*, HEALTHPOCKET.COM (Feb. 26, 2014), available at <http://www.healthpocket.com/healthcare-research/infostat/top-10-excluded-services-obamacare#.U-UFgvldV8E>.

¹²⁶ See *id.*

¹²⁷ See *id.*

¹²⁸ See, e.g., ULMER ET AL., *supra* note 27, at 99 (suggesting a number of steps to facilitate monitoring and learning from implementation of EHB requirements, including “standardized data collection and evaluation of appeals;” “examination of clinical policies;” and “[t]ransparency and disclosure of data and rationale on these decisions”).

to consumers if it is clear that a health service is not a covered service under the plan.¹²⁹ In New Jersey, consumers may file a complaint with the State Department of Banking and Insurance (“DOBI”),¹³⁰ but it is less clear how consumers may raise their concerns with HHS. The ACA places ultimate responsibility and authority for the enforcement of the preventive health and EHB requirements with HHS.¹³¹ It therefore is important that HHS monitor market behavior and state regulation concerning these required health benefits. The Sentinel Project will help create this necessary feedback loop among and between consumers, plans, and state and federal regulators.

Underlying each of these issues is the persistent need, as HHS has recognized, “to balance comprehensiveness, affordability, and State flexibility.”¹³² HHS has indicated that it will evaluate how its state-devolved benchmark approach to EHB implementation works in 2014 and 2015 before deciding how to define EHB for plan years 2016 and beyond.¹³³ New Jersey, too, should evaluate its regulatory options.¹³⁴ The Project’s careful monitoring and assessment of market behavior and consumer experiences should inform these efforts.

III. MEDICAL NECESSITY

As discussed in the prior Section, insurance contracts broadly cover a wide range of services such as hospitalization, physician services, pharmaceuticals, and diagnostic technologies. Within those broad categories of coverage, however, insurance contracts invariably limit care to that which is “medically necessary.” 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.

¹²⁹ See N.J.A.C. § 11:24A-3.6(a). DOBI undertakes a preliminary “cursory” review of the appeal to assess whether the dispute is over a covered service before forwarding the dispute to an IURO. The IURO then makes a coverage determination before reaching the medical necessity dispute. See N.J. Dep’t of Banking & Ins., *Independent Health Care Appeals Program*, available at http://www.nj.gov/dobi/division_insurance/managedcare/ihtcap.htm. See Section III(B), *infra*.

¹³⁰ See N.J. DEP’T OF BANKING & INS., *Div. of Ins. - Consumer Protection Servs.*, <http://www.state.nj.us/dobi/enfcon.htm> (last visited Aug. 8, 2014).

¹³¹ See 42 U.S.C. § 300gg-22(a)(2) (““In the case of a determination by the Secretary that a State has failed to substantially enforce a provision (or provisions) [regarding, *inter alia*, EHB provisions] . . . with respect to health insurance issuers in the State, the Secretary shall enforce such provision (or provisions) . . .”). The Secretary noted this responsibility in comments to the adoption of the final rule on EHBs. See *EHB Final Rule Preamble*, *supra* note 101, 78 Fed. Reg. at 12846.

¹³² EHB BULLETIN, *supra* note 92, at 1.

¹³³ See *id.* at 9; EHB FAQ, *supra* note 87, at 1; *EHB Final Rule Preamble*, *supra* note 101, at 12841-42.

¹³⁴ See, e.g., JUSTIN GIOVANNELLI ET AL., IMPLEMENTING THE AFFORDABLE CARE ACT: STATE ACTION TO REFORM THE INDIVIDUAL HEALTH INSURANCE MARKET, THE COMMONWEALTH FUND (July 2014), available at <http://www.commonwealthfund.org/publications/issue-briefs/2014/jul/state-action-reform-individual-market> (examining where states have flexibility to enact consumer protections that exceed federal minimum requirements).

This Section reviews the history of medical necessity decisions in insurance plans, and the systems that have developed to review those decisions. It focuses on the internal and external appeals programs that have developed under state and federal law over recent decades, as legislatures and regulators attempted to protect consumers while permitting or encouraging new forms of health insurance. Regulators have recognized the need for plans to contain costs and improve quality by engaging in review of utilization of health care. They also have recognized, however, the need to protect consumers from harm that could arise if plans are tempted to overreach in their utilization management efforts. As Carole Roan Gresenz and colleagues observed in 2002, “Procedural mechanisms for reviewing benefit denials have emerged as the darling of federal and state efforts to protect patients in managed care plans.”¹³⁵

A. Utilization Review and “Medical Necessity” Judgments

There is no straight-forward, generally accepted definition of medical necessity.¹³⁶ 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.¹³⁷ The leading insurance treatise summarizes the contractual bases for medical necessity denials as follows:

¹³⁵ Carole Roan Gresenz *et al.*, *Patients In Conflict With Managed Care: A Profile of Appeals in Two HMOs*, 21:4 HEALTH AFFAIRS 189 (2002).

¹³⁶ See, e.g., ULMER *ET AL.*, *supra* note 27, 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 34, at 601-02; Mark A. Hall & Gerald F. Henderson, *Health Insurers’ Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637, 1646-48 (1992).

¹³⁷ 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.” The range of responses is instructive:

One view was that the two terms were identical. A second was that medical necessity decisions determined clinical availability, while coverage decisions determined payment. A third was that medical necessity decisions determined the level and intensity of care (e.g., the right to see a specialist with particular skills), while coverage decisions merely verified the existence of some benefit. A fourth was that medical necessity decisions assessed existing practices, while coverage decisions assessed new technologies. A fifth view was that medical necessity decisions were based on individual patients’ clinical circumstances, while coverage decisions applied generally to the insured group. A sixth view was that coverage decisions were explicit contractual matters, whereas “medical necessity” was a deliberately ambiguous term because individual judgments at the margin cannot as a practical matter be specified contractually. One respondent referred to this as “conditional eligibility,” suggesting that care that

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 established by any state or federal government, and (5) not furnished in connection with medical or other research.¹³⁸

None of those categories provides a bright-line interpretive standard. Medical necessity review permits health insurers a contractual mechanism for reviewing some¹³⁹ 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 clarified to some extent to more clearly specify what services are covered, and which are excluded, so that insureds can more fully understand the nature of their bargain when they purchase particular health insurance coverage.¹⁴⁰ The infinite complexity of human medical conditions and the range of possible treatments guarantee that no contractual language can resolve all disputes, however. 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. Second, the treatment sought must be “effective” in treating illness or injury. Third, it must not be provided merely “as a convenience to the patient or provider.”¹⁴¹ These principles are intended to rule out coverage in cases in which treatment is simply outside accepted professional norms; not

was not “medically necessary” still might be covered under special circumstances, but not indicating on what basis—principled, compassionate, or discriminatory—such “exceptions” might be made.

Sage, *supra* note 34, at 603-04.

¹³⁸ STEVEN PLITT ET AL., COUCH ON INSURANCE § 181:2 (3D ED. 2013) (citations omitted).

¹³⁹ 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 136, at 1654 (citing INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE? THE ROLE OF UTILIZATION MANAGEMENT 4, 77 (Bradford H. Gray & Marilyn J. Field eds., 1989)). See Section III(C)(1), *infra*.

¹⁴⁰ See Section II, *infra*.

¹⁴¹ Linda A. Bergthold, *Medical Necessity: Do We Need It?*, 14:4 HEALTH AFFAIRS 180, 182-83 (1995).

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. Their use can also be problematic, as the inherent indeterminacy of medical necessity judgments can leave both insurer and insured uncertain of their rights and obligations. 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.¹⁴² There is even a risk, as is described in Section V below, that the indeterminacy of medical necessity judgments could permit disparate treatment of vulnerable groups.

Some uncertainty is sure to remain, regardless of attempts to narrow its range.¹⁴³ 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. The need for the scooter is related to the health condition resulting in the mobility impairment. It is undeniably convenient for many insureds with serious mobility impairments to have a scooter. But when is a convenient item of medical equipment "merely" convenient and not medically necessary? One insurer's published policy rejects coverage if the insured is able to "safely ambulate" within her home and needs the scooter only outside the home, or if the insured has "upper

¹⁴² 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:

By asking medical directors what criteria they used to make daily medical necessity decisions, and by comparing those criteria with the ones in their own contracts, we confirmed that contractual definitions of medical necessity vary and are not the primary driving force in practice. Instead, each medical director relies to a different extent on coverage policies, scientific evidence, expert opinion, committee consensus, personal experience, and patient characteristics and preferences when making daily decisions, while the contractual definition remains on the shelf as a reminder of legal obligations and risks.

Sara J. Singer & Linda A. Bergthold, *Prospects For Improved Decision Making About Medical Necessity*, 20:1 HEALTH AFFAIRS 200, 202 (2001) (footnote omitted).

¹⁴³ See Sage, *supra* note 34, at 598-99.

extremity strength” sufficient to propel a manual wheelchair.¹⁴⁴ Insurers and physicians can disagree on where the line should be drawn; it is clear that at some minor level of mobility impairment, the expensive¹⁴⁵ equipment is indeed a convenience item, while at a more significant level of mobility impairment, it can be a necessity. It also is clear that no amount of contractual language refinement can avoid differing, plausible interpretations of coverage in some cases. Dispute resolution procedures therefore are necessary.

B. 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.¹⁴⁶ 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.¹⁴⁷ Whether litigation proceeds under state contract causes of action (usually in state court) or under ERISA causes of action¹⁴⁸ (usually in federal court), a court’s ultimate judgment usually will depend on fact-specific analysis of the coverage requested, and opposing opinions on the medical necessity of that treatment.¹⁴⁹ The litigation process has been criticized as expensive and time-consuming, leading to inconsistent determinations by lay judges and jurors.¹⁵⁰

In the 1990s and 2000s, as part of the backlash against managed care, consumers pushed back against medical denials by plans. Federal and state regulators supplemented the expensive and lengthy litigation process with more

¹⁴⁴ PRIMERIA BLUE CROSS, *Medical Policy: Power Operated Vehicles (Scooters) (excluding motorized wheelchairs)* (Feb. 10, 2014), https://www.premera.com/medicalpolicies/CMI_157664.htm. The insurer notes in a Disclaimer in the Medical Policy that, “This medical policy is a guide in evaluating the medical necessity of a particular service or treatment,” and that the contract of insurance ultimately controls coverage issues. *Id.*

¹⁴⁵ The cost of four-wheeled scooters with a weight capacity of at least 300 pounds can range from about \$1,000 to well over \$3,000. *See Compare Mobility Scooters*, FINDTHEBEST.COM, <http://mobility-scooters.findthebest.com/> (on-line shopping site for durable medical equipment) (last visited Aug. 1, 2014).

¹⁴⁶ *See Sage*, *supra* note 34, at 610-11.

¹⁴⁷ Employee Retirement Income Security Act of 1974 (ERISA), Pub. L. No. 93-406, 88 Stat. 829 (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 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.

¹⁴⁸ 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 (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), *available at* <http://www.census.gov/prod/2013pubs/p70-134.pdf>.

¹⁴⁹ PLITT *ET AL.*, *supra* note 138, § 181:2.

¹⁵⁰ *See generally Sage*, *supra* note 34; Hall & Henderson, *supra* note 136.

accessible and timely processes of internal and external appeals.¹⁵¹ The internal appeals processes commonly came to have two stages, with the first stage consisting of review by a 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.¹⁵² 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.¹⁵³

Skepticism of insurers' internal review of medical necessity denials led many states to implement an external "independent utilization review" process that permitted insureds to seek review of denials from panels of independent, suitably qualified physicians.¹⁵⁴ These private independent utilization review organizations ("TUROS") "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."¹⁵⁵ Although prior to the ACA most plans subject to state regulation were required to provide independent external appeals as a matter of state law,¹⁵⁶ the ACA requires that all non-grandfathered individual and group health insurance plans provide external review as a matter of federal law.¹⁵⁷

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. Second, they are less formal, less expensive, and less time-consuming than litigation in state or federal courts. Third, they place decision-making authority over largely clinical decisions in the hands of specialized physicians, and not lay judges or juries,

¹⁵¹ See Gresenz *et al.*, *supra* note 135 at 189; Note, Susan J. Stayn, *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).

¹⁵² 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).

¹⁵³ See 45 C.F.R. §§ 147.136(a) and (b).

¹⁵⁴ *Id.*

¹⁵⁵ Geraldine Dallek & Karen Pollitz, *External Review of Health Plan Decisions: An Update*, at 8 (KAISER FAMILY FOUNDATION May 2000), available at <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/external-review.pdf>.

¹⁵⁶ *See id.*

¹⁵⁷ 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), available at <http://www.dol.gov/ebsa/newsroom/tr11-02.html#f12>.

thereby permitting the application of clinical expertise to medical necessity judgments.¹⁵⁸

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. Internal review can, however be opaque and subject to conflicts of interest. Independent review processes can correct for the structural conflicts of interest to which internal appeals are subject without entailing the cost and delays inherent in litigation. Independent review processes raise some concerns for consumers also, however. They are sometimes subject to shorter filing deadlines than are civil actions in courts; they require exhaustion of often multi-level internal appeals (with exceptions or expedited processes for emergency cases); while they are simpler than litigation, they 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; there are few sources of assistance to patients pursuing the process;¹⁵⁹ and the process cannot escape that "medical necessity" remains a murky concept, and even conflict-free expert physicians can disagree on its definition in any case.¹⁶⁰

The following Subsection describes the federal and New Jersey law applicable to internal and external appeal processes. We first discuss the law as it applies to insured plans governed by state law, subject to some federal procedural requirements as the ACA becomes effective. We then address the internal and external appeals requirements in self-funded plans, which plans are exempt from

¹⁵⁸ See Gresenz *et al.*, *supra* note 135 at 189.

¹⁵⁹ 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). Lack of state take-up and shortfalls in funding, however, have limited these programs. As of the date of this Report, 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).

New Jersey does have an Office of the Insurance Claims Ombudsman, see N.J. STAT. ANN. § 17:29E-1 *et seq.* DOBI has taken the position that the Ombudsman will not accept appeals in health insurance matters notwithstanding that the statute defines "claims" subject to the Ombudsman's review as including "any policy of life or health insurance issued pursuant to Title 17 of the Revised Statutes or Title 17B of the New Jersey Statutes." N.J. STAT. ANN. § 17:29E-1; see N.J. DEP'T OF BANKING AND INS., *Ombudsman's Office - Frequently Asked Questions*, http://www.state.nj.us/dobi/ins_ombudsman/ombudsfag.html (last visited Aug. 9, 2014) ("note: health insurance is not listed in the law since these policies provide separate appeal rights"). Consumers seeking to reverse a claim denial in a health insurance matter are therefore left to the appeals processes described below.

¹⁶⁰ See Leatrice Berman-Sandler, *Independent Medical Review: Expanding Legal Remedies to Achieve Managed Care Accountability*, 13 ANN. HEALTH LAW 1, 15-17 (2004); Dallek & Pollitz, *supra* note 155, at 4-6.

state insurance law, but are required, under the ACA, to provide consumers access to internal and external appeals.

1. Appeals in Insured Plans under New Jersey Law

New Jersey's legal provisions for internal and external appeals predate the passage of the ACA and required only modest adjustment to conform to the ACA's requirements.¹⁶¹ They apply to all individual coverage and to all insured group insurance regardless of the size of the group.¹⁶² The regulations require that plans provide appeals processes for "adverse benefit determinations," defined as:

a denial, reduction or termination of, or a failure to make payment (in whole or in part) for, a benefit, including a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for, a benefit resulting from application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because the carrier determines the item or service to be experimental or investigational, cosmetic or dental rather than medical, excluded as a pre-existing condition or because the carrier has rescinded the coverage.¹⁶³

Plans are required to provide information on internal and external appeals processes to insureds in writing at the time of coverage, when rendering an adverse benefits determination, and again following each stage of the appeals process.¹⁶⁴ Plans must "provide continued coverage of an ongoing course of treatment pending the outcome of" each stage of appeal.¹⁶⁵

The appeals process for group coverage has three stages, two internal and one external to the plan, while that for individual coverage has two stages, one

¹⁶¹ See 43 N.J.R. 2411(a) (Sept. 19, 2011) (proposed rules changes to conform existing New Jersey internal and external appeals rules to the ACA's requirements); 44 N.J.R. 2(1) (Feb. 6, 2102) (rules adoption).

¹⁶² See N.J.A.C. § 11:24A-1.2 (definitions applicable to all state-licensed insurers, as well as state-chartered entities such as those operating as Blue Cross Blue Shield entities). New Jersey, for historical reasons, maintains separate regulatory regimes for Health Maintenance Organizations ("HMOs") and other state-licensed health insurance carriers, notwithstanding the blurring of the distinctions among those forms of health coverage in recent years. The definition of the term "adverse benefit determination" applicable to HMOs tracks that applicable to other health insurers, except that the term "carrier" is replaced by "HMO" in the definition. See N.J.A.C. § 11:24-1.2. Except where the context requires otherwise, this Section will refer to all health insurance products covered by one or the other of these sets of regulations as "plans."

¹⁶³ *Id.* §§ 11:24A-1.2 (non-HMO plans); 11:24-1.2 (HMOs).

¹⁶⁴ *Id.* §§ 11:24A-3.5(b) (non-HMO plans); 11:24-8.4(a) (HMOs).

¹⁶⁵ *Id.* §§ 11:24A-3.5(i) (non-HMO plans); 11:24-8.4(f) (HMOs).

internal and one external.¹⁶⁶ A Stage 1 appeal is informal, giving the insured an opportunity to speak¹⁶⁷ and present evidence¹⁶⁸ to the person who rendered the medical necessity denial on behalf of the plan – the medical director or her designee. The response from the insurer must be timely, and a decision must be communicated:

[within 72 hours for] an appeal from an adverse benefit determination regarding urgent or emergency care, an admission, availability of care, continued stay and health care services for which the claimant received emergency services but has not been discharged from a facility[] and [within] [t]en calendar days in the case of all other appeals.¹⁶⁹

The written explanation of the Stage 1 appeal decision must include an explanation of the insured’s further appeal rights to a Stage 2 internal appeal for those with group coverage, and to an external appeal for those with individual coverage.¹⁷⁰ The notice must include information on time limits and instructions on how to file further appeals.¹⁷¹

For those with group coverage, an unfavorable decision at a Stage 1 appeal permits resort to a Stage 2 appeal. The appeal proceeds “before a panel of physicians and/or other providers selected by the carrier who have not been

¹⁶⁶ *Id.* §§ 11:24A–3.5(e) (non-HMO plans); 11:24–8.4(a) (HMOs). Prior to 2012, the regulations required a two-stage process of internal appeals for both individual and group coverage. In 2012, the regulations were amended, *see* 43 N.J.R. 2411(a) (Sept. 19, 2011) (proposed rules changes); 44 N.J.R. 2(1) (Feb. 6, 2102) (rules adoption), to conform to the provisions in federal regulations requiring that the internal appeals process for individual coverage be limited to one internal appeal, *see* 45 C.F.R. § 147.136(b)(3)(G).

¹⁶⁷ N.J.A.C. § 11:24A–3.5(j) (non-HMO plans); N.J.A.C. § 11:24–8.5 (HMOs).

¹⁶⁸ Although the New Jersey regulations do not specifically address the ability of an insured to present evidence at a Stage 1 appeal, the ACA requires that the insured be permitted to do so. *See* 42 U.S.C. § 300gg-19(a)(1)(C). New Jersey law will therefore be interpreted to permit the presentation of evidence as well as testimony, as it must comply with directly applicable federal law.

¹⁶⁹ N.J.A.C. § 11:24A–3.5(j)(1)(i) and (ii) (non-HMO plans); *see* N.J.A.C. § 11:24–8.5 (HMOs).

¹⁷⁰ Prior to 2002, the law was unclear on the reach of states’ external appeal regulations. Insurers argued that states were barred by ERISA’s preemption provisions, 29 U.S.C § 1144(a) and (b)(2)(B), from mandating that consumers have access to external appeals processes where the insurance coverage was an incident of employment. Consumers and states disagreed, arguing that the external appeals laws are simply the regulation of insurance, and therefore proper under ERISA, 29 U.S.C. § 1144(b)(2)(A). In 2002, the United States Supreme Court resolved this issue, finding that states have the authority under ERISA to mandate the availability of external appeals even where coverage is an incident of employment, so long as the coverage is in the form of an insured plan, where the insurer is subject to state insurance licensure. *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002). Self-funded plans are not subject to state licensure, and therefore are not subject to states’ external appeal mandates. Most self-funded plans, however, are subject to the ACA’s requirement of external review procedures for self-funded plans. *See* Section III(B)(2), *infra*.

¹⁷¹ N.J.A.C. §§ 11:24A–3.5(j)(2) (non-HMO plans); 11:24–8.5 (HMOs).

involved in the adverse benefit determination at issue.”¹⁷² The process for a Stage 2 appeal is somewhat more formal than that for a Stage 1 appeal. The regulations specify the following requirements:

- The panel must have access to suitably qualified experts with no previous involvement in the case;
- The plan must acknowledge receipt of the appeal in writing within ten days;
- The plan must decide the appeal within seventy-two hours for urgent or emergent cases, and twenty business days for other cases; and
- If the plan denies the appeal at this stage, it must provide the consumer with written notice of the reasons for denial, and written instructions and forms for an external appeal.¹⁷³

The conclusion of the internal appeals process, if unfavorable to the insured, permits the insured to invoke an external appeal through the Independent Health Care Appeals Program administered through DOBI.¹⁷⁴ This independent appeals system has been required of New Jersey plans since 1997,¹⁷⁵ and allows appeals beyond the plan itself, to an IURO.¹⁷⁶ New Jersey’s external appeals program has been determined by federal regulators to be structurally and procedurally compliant with requirements of the ACA.¹⁷⁷ The request for external review must be filed

¹⁷² *Id.* §§ 11:24A–3.5(k) (non-HMO plans); 11:24–8.6(a) (HMOs).

¹⁷³ *Id.* §§ 11:24A–3.5(k) (non-HMO plans); 11:24–8.6(a) (functionally similar requirements for HMOs).

¹⁷⁴ N.J. STAT. ANN. § 26:2S-11. Exhaustion of internal appeals is required prior to entitlement to an external appeal, unless the plan materially defaults on its internal appeals procedure obligations to the detriment of the consumer; the plan consents to the bypass of internal appeals, or there is an urgent or emergent appeal. *See* N.J.A.C. § 11:24A-3.5(l). The external appeal is clearly limited to challenges of medical necessity and excludes consideration of “denials based on eligibility, including rescission, or the application of a contract exclusion or limitation not related to medical necessity.” N.J.A.C. § 11:24A–3.6(a).

¹⁷⁵ The Health Care Quality Act, L. 1997, C. 192, § 11 (1997).

¹⁷⁶ An IURO is defined as “an independent organization with which [DOBI] contracts to provide independent reviews through the Independent Health Care Appeals Program of carrier determinations regarding medical necessity or appropriateness of services which are contested by the covered person or a provider on behalf of the covered person.” *See* N.J.A.C. §§ 11:24A–1.2 (non-HMO plans); 11:24–1.2 (HMOs).

¹⁷⁷ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, U.S. DEP’T OF HEALTH & HUMAN SERVS., *Affordable Care Act: Working with States to Protect Consumers, State External Appeals Review Processes* (updated May 24, 2014), available at http://www.cms.gov/ccio/resources/files/external_appeals.html; *see also* 45 C.F.R. § 147.136(c) (describing standards for assessing state programs for compliance with ACA requirements).

with DOBI along with a twenty-five dollar filing fee, within four months of the plan's final denial of internal appeals.¹⁷⁸

As a preliminary matter, an IURO receiving an appeal must evaluate the appeal to ensure that it fits within the external appeal program's mandate. It must determine whether:

1. The individual was or is a covered person of the carrier specified;
2. The service that is the subject of the appeal reasonably appears to be a service covered under the terms of the contract or policy for which some level of benefit is payable; and
3. The covered person . . . has provided all information required by the IURO and the Department to make a preliminary determination¹⁷⁹

If the appeal meets all three conditions, it then is referred for review to an "expert physician in the same specialty or area of practice that generally would manage the type of treatment that is the subject of the appeal," who reviews the record and, in consultation with the IURO's medical director, renders a decision.¹⁸⁰ The IURO's decision is to be rendered within forty-five days, unless the exigencies of the matter require that it be decided more quickly.¹⁸¹ The decision of the IURO is a final decision of the internal and external appeals process, although the regulations leave open recourse by either party to remedies "available to either party under State or Federal law."¹⁸²

2. Self-funded Plans: ERISA and the ACA

The Sentinel Project's primary focus is on the market behavior of insurers subject to New Jersey's insurance regulation. The previous Subsection describes the rules applicable to medical necessity disputes that arise for insurers subject to state law. A majority of Americans insured through employment, however, do not have coverage subject to state insurance regulation. Instead, their employers self-

¹⁷⁸ N.J.A.C. § 11:24A-3.6(a) and (b) (non-HMO plans); *see id.* § 11:24-8.7(b) and (c) (HMOs). The filing fee can be waived on a demonstration of hardship. *Id.* §§ 11:24A-3.6(b) (non-HMO plans); 11:24-8.7(c) (HMOs).

¹⁷⁹ *Id.* §§ 11:24A-3.6(f) (non-HMO plans); 11:24-8.7(e) (HMOs).

¹⁸⁰ *Id.* §§ 11:24A-3.6(g) (non-HMO plans); 11:24-8.7(h) (HMOs).

¹⁸¹ *Id.* §§ 11:24A-3.6(h) and (i) (non-HMO plans); 11:24-8.7(i) (HMOs).

¹⁸² *Id.* §§ 11:24A-3.6(j)(2)(non-HMO plans); 11:24-8.7(k)(HMOs). Courts have responded to this language by permitting insureds disappointed by IURO decisions to pursue judicial remedies under ERISA. *See, e.g.,* *Mirsky v. Horizon Blue Cross and Blue Shield of New Jersey*, Civil Action No. 2:11-cv-02038, 2013 WL 5503659 (Sept. 30, 2013) (permitting insured to pursue claim for reimbursement of costs incurred due to denial of coverage under 29 U.S.C. § 1132(a)(1)(B)).

fund¹⁸³ and do not purchase state-licensed insurance for their employees and their dependents. These self-funded plans are beyond the reach of state medical necessity regulation.¹⁸⁴ We address the procedures for medical necessity appeals for persons covered by self-funded plans in this Subsection.

Over half of all Americans obtain health coverage as an incident of their employment, or through the employment of another – usually a family member.¹⁸⁵ A majority of those with health benefits through an employment relationship are covered by self-funded plans.¹⁸⁶ Prior to the enactment of the ACA, the United States Department of Labor (“DOL”) promulgated regulations on internal appeals processes for employment-based coverage.¹⁸⁷ Following the enactment of the ACA, the procedures for internal appeals were expanded. Under current regulations, employment-based plans are required to provide timely notice of adverse benefits decisions; permit claimants to present evidence and testify in support of their claims; provide unbiased decision-makers; and make timely decisions, with the

¹⁸³ 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) 13-14 RAND CORPORATION TECHNICAL REPORT FOR THE U.S. DEPT OF LABOR (2011), available at http://www.rand.org/pubs/technical_reports/TR971.html.

¹⁸⁴ Not all employment-based insurance, of course, is beyond the reach of state insurance law. Employment-based coverage, if it is provided through an insured plan, is fully subject to state insurance law, including state law on appeals from medical necessity denials. The precise extent of ERISA’s preemption is beyond the scope of this Report. See Aaron S. Kesselheim and Troyen A. Brennan, *The Swinging Pendulum: The Supreme Court Reverses Course on ERISA and Managed Care*, 5 YALE J. HEALTH POL’Y L. & ETHICS 451 (2005); Russell Korobkin, *Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457 (2003-2004). The extent of ERISA’s preemption of mandates for external and internal appeals, however, has been clear and simply stated since 2002. The United States Supreme Court held in *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355 (2002), that ERISA does not preempt state insurance regulation mandating recourse to external appeals for medical necessity denials, where that regulation applies to coverage provided by licensed insurance companies. The Court left intact, however, ERISA’s preemption of state regulation of self-funded plans, and the regulation of the market behavior of these self-funded plans is therefore subject to regulation by the U.S. Department of Labor. See 29 U.S.C. § 1144(b)(2)(B).

¹⁸⁵ JANICKI, *supra* note 148, available at <http://www.census.gov/prod/2013pubs/p70-134.pdf> (footnote omitted); see also THE KAISER FAMILY FOUNDATION AND HEALTH RESEARCH & EDUCATIONAL TRUST, EMPLOYER HEALTH BENEFITS: 2013 ANNUAL SURVEY 176-77 (2013), available at <http://kff.org/private-insurance/report/2013-employer-health-benefits/>.

¹⁸⁶ See WILLIAM PIERRON, AND PAUL FRONSTIN, ERISA PRE-EMPTION: IMPLICATIONS FOR HEALTH REFORM AND COVERAGE, EMPLOYEE BENEFIT RESEARCH INSTITUTE RESEARCH BRIEF NO. 314 (Feb. 2008) at 10-11 (approximately 73 million persons covered by self-funded plans in 2006).

¹⁸⁷ See EIBNER *ET AL.*, *supra* note 183, at 36-37. Employment-based insured plans’ internal appeal process was and is also subject to state insurance laws, *id.* at 37, which in many cases are more detailed and stringent than federal regulations. See, e.g., N.J.A.C. §§ 11:24A–3.5(j)(1)(i) and (ii) (non-HMO plans); 11:24–8.5 (HMOs).

rationale for the decision clearly stated, along with notice of the availability of additional review.¹⁸⁸

The ACA's major change for non-grandfathered self-funded plans was the requirement that they provide the opportunity for external appeals.¹⁸⁹ The federal agencies responsible for implementation of the ACA's appeals provisions¹⁹⁰ set out Technical Guidance for self-funded plans providing two options for establishing compliance with the ACA's external review requirement.¹⁹¹ One option was for a self-funded plan to "voluntarily" comply with the external review procedures applicable to insured plans in the state in which the issue arises.¹⁹² If a self-funded plan were to adopt that option, then plan members covered by insured and self-funded plans would enjoy the same appeal rights. The second option was to comply with the standards and procedures set out in the Technical Guidance provided by the DOL.¹⁹³ The requirements of these federal standards and procedures are substantially similar to the requirements for insured employment-based plans in New Jersey, as described above.¹⁹⁴ Under the ACA, then, the internal and external appeals processes of insured and self-funded employment-based plans have nearly converged. The standards for insured plans must conform both to the federal standards from the ACA and to state standards, which may be more detailed.

C. The Importance of Medical Necessity Review and Denials

1. The Numbers: Denials, Appeals, Reversals

As was described at the beginning of this Section, access to appropriate care requires three things: insurance coverage, an insurance contract that covers medically appropriate modalities of care, and processes calculated to resolve disputes over medical necessity. There apparently are no data sources gathering insurance companies' or plan administrators' denial rates.¹⁹⁵ RAND Corporation researchers examined past studies and found indications of enormous numbers of claims denials.¹⁹⁶ 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

¹⁸⁸ See 29 C.F.R. § 2590.715-2719(b).

¹⁸⁹ See *id.* § 2590.715-2719(d).

¹⁹⁰ The DOL, HHS, and the Department of the Treasury are jointly responsible for the regulation of the appeals provisions for self-funded plans. See DOL TECHNICAL RELEASE 2010-01, at 1 (Aug. 23, 2010), available at <http://www.dol.gov/ebsa/pdf/ACATEchnicalRelease2010-01.pdf> [hereinafter "T.R. 2010-01"].

¹⁹¹ *Id.*

¹⁹² *Id.* at 3.

¹⁹³ *Id.* at 2. The Technical Guidance adopted the "Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners (NAIC Model Act) . . . in place on July 23, 2010." *Id.*

¹⁹⁴ See text accompanying *supra* notes 174-182.

¹⁹⁵ See EIBNER *ET AL.*, *supra* note 183, at 32.

¹⁹⁶ *Id.* at 29.

rates in Medicaid plans.¹⁹⁷ These 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.¹⁹⁸

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.”¹⁹⁹ Researchers from the RAND Corporation subsequently provided more detailed information about denial rates through interviews of plan decision-makers and review of administrative documents.²⁰⁰ They found that these sources reported overall denial rates of six percent for prospective coverage requests and twenty-three percent for retrospective requests.²⁰¹ They 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 grounds that the care was not medically necessary.²⁰²

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?²⁰³ These researchers had access to the internal appeals records kept by two California HMOs, with combined enrollment of “several million commercial HMO enrollees.”²⁰⁴ The HMOs had slightly different internal appeals processes. One had a two-step, and the other a three-step internal appeals process. The rates of appeal “were virtually identical at the two plans, with approximately 3.5 [appeals] per thousand enrollees per year.”²⁰⁵ Approximately seventy percent of the appeals from one of the plans were from prospective denials. 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.²⁰⁶ The internal appeals process favored the enrollee, and resulted in a reversal of the original denial, in 70.3 percent of cases.²⁰⁷

¹⁹⁷ *Id.*

¹⁹⁸ *Id.* at 32-33.

¹⁹⁹ Hall & Henderson, *supra* note 136, at 1654 (citing INSTITUTE OF MEDICINE, CONTROLLING COSTS AND CHANGING PATIENT CARE?, *supra* note 139).

²⁰⁰ See Kanika Kapur *et al.*, *Managing Care: Utilization Review In Action At Two Capitated Medical Groups*, HEALTH AFFAIRS 2003 Web Exclusive, W3-275 (2003), available at <http://content.healthaffairs.org/content/early/2003/06/18/hlthaff.w3.275.full.pdf+html>; Gresenz *et al.*, *supra* note 135, at 190.

²⁰¹ Kapur, *et al.*, *supra* note 200, at W3-279.

²⁰² *Id.*

²⁰³ Gresenz *et al.*, *supra* note 135, at 190.

²⁰⁴ *Id.*

²⁰⁵ *Id.* at 191.

²⁰⁶ *Id.* at 191, 193.

²⁰⁷ *Id.* at 192.

In New Jersey, DOBI reports the raw numbers of external appeals and the prevailing party in those appeals. DOBI reports semiannually on the number of consumers who file a request for external medical necessity appeals. The number of New Jersey external appeals is approximately 500 per year, with about 185 decided in favor of the consumer-claimant.²⁰⁸

2. 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. 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.²⁰⁹ 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.²¹⁰ 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.

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 in New Jersey and nationally 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.²¹¹ 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: how to ensure that the

²⁰⁸ See N.J. DEP'T OF BANKING AND INS., *Independent Health Care Appeals Program, Table 2: July 16, 2013-January 15, 2014, available at http://www.state.nj.us/dobi/division_insurance/managedcare/ihcareports.htm* (annualized by multiplying six month results by two).

²⁰⁹ See Singer & Bergthold, *supra* note 142, at 201.

²¹⁰ See Sage, *supra* note 34, at 605-06.

²¹¹ See Gresenz *et al.*, *supra* note 135, at 194.

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.²¹²

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.²¹³ Examination of 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.²¹⁴ It is unclear whether the reported data capture the extent of disputes between plans and patients. If they do not, and if the inconvenience of pursuing appeals or other inhibitions created by the health insurance system 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.²¹⁵

IV. NETWORK ADEQUACY

Without an adequate supply of qualified and available health care providers, consumers cannot access appropriate care. Most health plans 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. In recent years, the breadth of these networks has waxed and waned. In

²¹² See Daniel Skinner, *Defining Medical Necessity under the Patient Protection and Affordable Care Act*, 73 PUBLIC ADMINISTRATION REVIEW S51 (2013); see Section V, *infra*.

²¹³ See Singer & Bergthold, *supra* note 142, at 201.

²¹⁴ See EIBNER *ET AL.*, *supra* note 183, at 32-33.

²¹⁵ See Gresenz *et al.*, *supra* note 135, at 194.

the 1980s and early 1990s, narrow provider-network HMOs competed with broader plans. After a consumer backlash against perceived restrictions in access to care, HMOs turned away from narrow network models. At the same time, non-HMO insurers were creating networks of their own, blurring the lines between HMOs and other forms of coverage. On one hand, few plans maintained narrow networks. On the other, most plans did maintain a defined panel of in-network providers which insureds either were limited to or strongly incented to use.²¹⁶

Narrow networks²¹⁷ 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. Plans can then pass their savings from paying providers less on to enrollees in the form of lower premiums.²¹⁸ 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 management, which is particularly important for high-needs insureds with chronic illnesses.²¹⁹

Narrow networks and tiered networks also can present risks, which can be mitigated with sound consumer protection measures. First, narrow networks may impose significant financial hardship due to unavailability of care. Care might be unavailable if in-network providers are not geographically proximate to the insured or are not taking appointments within a medically reasonable time, or if no network provider is qualified to provide particular medically-necessary care.²²⁰ Resort to

²¹⁶ See SABRINA CORLETTE *ET AL.*, NARROW PROVIDER NETWORKS IN NEW HEALTH PLANS: BALANCING AFFORDABILITY WITH ACCESS TO QUALITY CARE, CENTER ON HEALTH INSURANCE REFORMS, GEORGETOWN UNIVERSITY HEALTH POLICY INSTITUTE AND THE URBAN INSTITUTE 2 (May 29, 2014), available at <http://www.urban.org/publications/413135.html>; Marc A. Rodwin, *The Metamorphosis of Managed Care: Implications for Health Reform Internationally*, J. LAW, MED., & ETHICS 352, 357-58 (2010).

²¹⁷ 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 Incentives*, HEALTH AFFAIRS, W3-35, 36 (2003).

²¹⁸ See James C. Robinson, *Reinvention of Health Insurance in the Consumer Era*, 291 JAMA 1880, 1882 (2004). Note that the increasing concentration of providers in consolidated business models weakens insurers' bargaining position. See CORLETTE *ET AL.*, *supra* note 216, at 3.

²¹⁹ See Sabrina Corlette, *State Insurance Exchanges Face Challenges In Offering Standardized Choices Alongside Innovative Value-Based Insurance*, 32 HEALTH AFFAIRS 418, 419 (2012); James C. Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*, 29 HEALTH AFFAIRS 2009, 2010 (2010) [hereinafter "Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*"].

²²⁰ See Tracy Jan, *UnitedHealthcare to cut doctors for Mass. Seniors*, BOSTON GLOBE (June 7, 2014), available at <http://www.bostonglobe.com/news/nation/2014/06/06/unitedhealthcare-cut-hundreds-bay-state-doctors-from-its-medicare-advantage-network/ZK9ipRZ9KKVtIyGV87XXNI/story.html>; Ricardo Alonzo-Zaldivar, *Concerns about cancer centers under health law*, U-T SAN DIEGO (March 18, 2014), available at <http://www.utsandiego.com/news/2014/Mar/18/concerns-about-cancer-centers-under-health-law/>.

out-of-network or higher-tier providers may leave the insured responsible for paying substantial out-of-pocket costs.²²¹ 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.²²² 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.²²³

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 networks²²⁴ and tiered networks.²²⁵ The costs and 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,²²⁶ deferring instead to the states as the primary regulators of private health insurance. Prior to the ACA, nearly all states had adopted network adequacy standards for HMOs and approximately half of the

²²¹ See Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*, *supra* note 219, at 2010.

²²² See *Out-of-pocket maximum/limit*, HEALTHCARE.GOV, available at <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (last visited Aug. 4, 2014).

²²³ See Robinson, *Applying Value-Based Insurance Design To High-Cost Health Services*, *supra* note 219, at 2010.

²²⁴ See MCKINSEY CTR. FOR U.S. HEALTH SYSTEM REFORM, HOSPITAL NETWORKS: UPDATED NATIONAL VIEW OF CONFIGURATIONS ON THE EXCHANGES, at 1 (June 2014), available at <http://healthcare.mckinsey.com/hospital-networks-updated-national-view-configurations-exchanges> [hereinafter MCKINSEY CTR.].

²²⁵ 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).

²²⁶ The federal government does regulate network adequacy in public programs, including Medicare Advantage and Medicaid Managed Care plans. See generally Quynh Chi Nguyen, COMMUNITY CATALYST, *Network Adequacy: What Advocates Need to Know*, at 3 (Jan. 2014), available at <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*, THE JOURNAL OF RURAL HEALTH, Vol. 29, at 329-30 (2013).

states had standards for preferred provider organizations (“PPOs”).²²⁷ Most states employ broad, subjective standards, such as requiring “reasonable access” to providers.”²²⁸ Some states have opted for quantitative standards, including establishing provider-to-enrollee ratios and maximum travel times, travel distances, and appointment wait times, and requiring a minimum number of providers who are accepting new patients and who are available in a given service area.²²⁹ 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.²³⁰ The National Association of Insurance Commissioners (“NAIC”) developed a model law, the Managed Care Plan Network Adequacy Model Act #74, which recommends that state regulation address:

- 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[.]²³¹

1. New Jersey Regulation of Network Adequacy

New Jersey has taken a relatively prescriptive and quantitative approach to regulating network adequacy in its individual and small group markets.²³² Entities

²²⁷ See MCKINSEY CTR., *supra* note 224, at 1.

²²⁸ See LAURA SPICER *ET AL.*, MD. HEALTH BENEFIT EXCHANGE (MHBE) STANDING ADVISORY COMM., *NETWORK ADEQUACY AND ESSENTIAL COMMUNITY PROVIDERS*, at 13-14, THE HILLTOP INSTITUTE (Jul. 9, 2014), available at <http://marylandhbe.com/wp-content/uploads/2014/07/Essential-Community-Providers.pdf>; see also Nguyen, *supra* note 226, at 2 (“Most states have broad standards requiring health plans in the private insurance market to have a ‘robust’ or ‘sufficient’ market.”).

²²⁹ See SPICER *ET AL.*, *supra* note 228, at 13-14.

²³⁰ *Id.* at 3, 17.

²³¹ Nguyen, *supra* note 226, at 2; see also NAT’L ASSOC’N OF INS. COMM’RS, MANAGED CARE PLAN NETWORK ADEQUACY MODEL ACT #74 (Oct. 1996), available at <http://www.naic.org/store/free/MDL-74.pdf>; 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).

²³² See generally N.J. STAT. ANN. § 17B:27A-4.7 (authorizing a carrier in the individual market to offer one or more plans through its network of providers without reimbursement for out-of-network benefits other than emergency care, urgent care, and continuity of care but subjecting that network “to review and approval or disapproval by the Commissioner of Banking and Insurance, in consultation with the Commissioner of Health, pursuant to regulations promulgated by the

licensed by the State as HMOs²³³ must “maintain primary, specialty, ancillary, and institutional services sufficient to” provide or arrange for the provision of health services as defined by New Jersey law, including basic comprehensive health care services, emergency and urgent care services, supportive services, health promotion programs, treatment of Wilm’s tumor, and prescription drugs.²³⁴

The regulations employ a variety of standards and metrics to give meaning to New Jersey’s general requirement that HMOs “maintain an adequate network of primary care providers, specialists, and other ancillary health care personnel to serve the enrolled population at all times.”²³⁵ For example, with respect to the requirement that carriers have a sufficient number of licensed primary care providers (“PCP”s) under contract to provide basic comprehensive health care services, the regulations further specify that there must be at least two physicians within the lesser of ten miles or thirty minutes of average driving time or public transportation, if available, of ninety percent of the plan’s enrolled population.²³⁶ To demonstrate availability of sufficient numbers of PCP providers, the regulations assume that each projected adult, pediatric, and primary obstetric and gynecologic enrollee will need four primary care visits per year, for an average of one hour per year per member.²³⁷ The HMO also must “verify that the PCP has committed to provide a specific number of hours for new patients that cumulatively add up to projected clinic hour needs of projected enrollment by county or service area.”²³⁸ PCP network sufficiency further requires the HMO to provide immediate triage for emergencies through either a PCP or hospital emergency room; urgent care within twenty-four hours of notification of the PCP or HMO; access to triage services for emergent or urgent care twenty-four hours per day, seven days per week; routine appointments within two weeks; and routine physical exams within four months.²³⁹

The regulations also include standards to ensure HMO networks have a “sufficient number of licensed medical specialists . . . to provide medically necessary specialty care.”²⁴⁰ Ninety percent of members within each county or sub-county must be able to access specialists within the lesser of 45 miles or one hour of driving, including, but not limited to, cardiologists, dermatologists, endocrinologists, otolaryngologists (ENTs), general surgeons, neurologists, obstetrician/gynecologists,

Department of Banking and Insurance”); N.J. STAT. ANN. § 17B:27A-19.11 (same regarding small employer health benefit plans).

²³³ See N.J.A.C. § 11:24-6.2(a)(1)(i). “Health maintenance organization (HMO)’ means any individual or entity that undertakes to provide or arrange for basic comprehensive health care services through an organized system that combines the delivery and financing of health care on a prepaid basis to members.” *Id.* § 11:24-1.2.

²³⁴ *Id.* § 11:24-6.1 (referencing *id.* § 11:24-5).

²³⁵ *Id.* § 11:24-6.2(a).

²³⁶ *Id.* § 11:24-6.2(d)(1).

²³⁷ *Id.* § 11:24-6.2(d)(2)(i)-(ii).

²³⁸ *Id.* § 11:24-6.2(d)(3).

²³⁹ *Id.* § 11:24-6.2(d)(4)(i)-(v).

²⁴⁰ *Id.* § 11:24-6.2(a)(1)(ii).

oncologists, ophthalmologists, orthopedists, oral surgeons, psychiatrists, and urologists.²⁴¹

In addition to individual medical providers, New Jersey HMOs must include institutional providers that have the “capability to meet the medical needs of members and are geographically accessible.”²⁴² The following must be available within no greater than twenty miles or thirty minutes driving time, whichever is less, from ninety percent of the HMO’s members within the county or service area:

- “At least one licensed acute care hospital including at least licensed medical-surgical, pediatric, obstetrical, and critical care services in any county or service area”²⁴³
- “Surgical facilities including acute care hospitals, licensed ambulatory surgical facilities, and/or Medicare-certified physicians surgical practices available in each county or service area”²⁴⁴
- Certain specialized services that are medically necessary, namely, a licensed long term care facility with Medicare-certified skilled nursing beds; therapeutic radiation provider; magnetic resonance imaging center; diagnostic radiology provider, including x-ray, ultrasound, and CAT scan; emergency mental health service, including a short term care facility for involuntary psychiatric admissions; out-patient therapy providers for mental health and substance abuse conditions; and licensed renal dialysis provider.²⁴⁵

Additionally, the following specialized services must be available to ninety percent of members within each country or sub-county area within the lesser of forty-five miles or sixty minutes average driving time, when medically necessary:

- (1) At least one hospital providing regional perinatal services;
- (2) A hospital offering tertiary pediatric services;
- (3) In-patient psychiatric services for adults, adolescents and children;
- (4) Residential substance abuse treatment

²⁴¹ *Id.* § 11:24-6.1(a)(1)(ii)-(iii). The regulations also generally require that sufficient numbers of “other health professional staff,” such as nurses, are available to members to provide basic health care services, and that consumers have access to sufficient optometrists to provide vision care services, where appropriate. *Id.* § 11:24-6.1(a)(1)(iv)-(v). If an HMO provides a pharmacy benefit, it may not deny a registered pharmacy or pharmacist the right to participate as a preferred provider. *Id.* § 11:24-6.1(a)(1)(vi).

²⁴² *Id.* § 11:24-6.3(a).

²⁴³ *Id.* § 11:24-6.3(a)(1).

²⁴⁴ *Id.* § 11:24-6.3(a)(2).

²⁴⁵ *Id.* § 11:24-6.3(a)(3)(iii). Driving time must be based on public transportation transit times in counties or sub-counties where twenty percent of membership uses public transportation to access health services. *See id.* § 11:24-6.3(c). If an HMO can provide sufficient documentation that patients have access to alternative sites, the plan may be exempted from the specific mileage, and time requirements may be lifted. *See id.* § 11:24-6.3(b).

center; (5) Diagnostic cardiac catheterization services in a hospital; (6) Specialty out-patient centers for HIV/AIDs, sickle cell disease, hemophilia, and cranio facial and congenital anomalies; and (7) Comprehensive rehabilitation services.²⁴⁶

HMO networks must also provide access to medically necessary trauma services at all Level I or II Trauma Centers in New Jersey.²⁴⁷ In any county where 1,000 or more members reside, the HMO network must include at least one licensed home health agency and at least one hospice program certified by Medicare.²⁴⁸

New Jersey's regulations implementing the Health Care Quality Act ("HCQA") also include network adequacy standards for all managed care plans offered by New Jersey carriers when there is a difference between in and out of network benefits for one or more covered services or the policy includes a gatekeeper system.²⁴⁹ These managed care standards largely mirror those that apply to HMOs and apply only to services that are provided by the plan in-network.²⁵⁰ An Organized Delivery System ("ODS") also is required to comply with the HMO and HCQA network adequacy regulations "for those categories of providers in the ODS' network with respect to those services that the providers are required to render."²⁵¹

Choice and accessibility of network providers and compliance with the State's network adequacy requirements are among the bases on which consumers may file an appeal, as discussed in Section III above.²⁵² If an inadequate number of qualified network providers is available to provide medically necessary covered benefits, the plan must approve an in-network exception.²⁵³ If the plan fails to do

²⁴⁶ *Id.* § 11:24-6.3(a)(3)(ii).

²⁴⁷ *Id.* § 11:24-6.3(a)(3)(i).

²⁴⁸ *Id.* § 11:24-6.3(a)(4)-(5).

²⁴⁹ *Id.* § 11:24A-4.10; *see also id.* § 11:4-37.3(a) (noting that "[a] selective contracting arrangement that involves direct contracting between the carrier and network providers or that involves a contract between the carrier and a PPO shall contain an adequate number of network providers by specialty to render the particular covered services in the geographic service area where it operates"). The bulk, if not all, of plans offered in New Jersey's individual and small group markets are HMO or other managed care plans and are thus bound by these network adequacy requirements.

²⁵⁰ *Id.* § 11:24A-4.10(a)(1).

²⁵¹ *Id.* § 11:24B-3.5(b); *see also id.* § 11:4-37.3(a) (noting that "[a] selective contracting arrangement that involves direct contracting between a carrier and a licensed or certified ODS, or under which an HMO makes its network available to a carrier, shall be presumed to have an adequate provider network"). An ODS is "an entity with defined governance that contracts with a carrier to provide or arrange for the provision of one or more types of health care services to covered persons under a carrier's health benefits plan(s)." *Id.* § 11:24B-1.2.

²⁵² *See id.* § 11-24A-4.6(a).

²⁵³ *See* Notes of Interviews with N.J. Dep't of Banking & Ins. Staff (on file with authors); *accord* NAIC HEALTH INS. & MANAGED CARE (B) COMM., PLAN MGT. FUNCTION: NETWORK ADEQUACY WHITE PAPER, at 6 (June 27, 2012), available at http://www.naic.org/documents/committees_b_related_wp_network_adequacy.pdf ("If a health carrier

so, a consumer may appeal the effective denial of a covered benefit as an adverse benefit determination through the internal and external appeal processes, as discussed above.²⁵⁴

But as DOBI recently noted, some covered individuals do not appeal these denials.²⁵⁵ Thus, in the face of “recurring instances” of patients being unable “to obtain in-network benefits for the services of non-network surgeons performing breast reconstruction” following a mastectomy, the agency issued Bulletin 13-10 on May 3, 2013, reminding carriers that “[t]he Department views this matter as a network access and adequacy issue and believes that covered persons should not have to file medical necessity appeals in order to receive these services at the in-network level of benefits where in-network breast reconstruction surgeons do not perform the procedure requested or are not associated with the team of network surgeons who perform the mastectomy.”²⁵⁶ If plans cannot satisfy the State’s network adequacy standards, “plans must approve the use of out-of-network specialists.”²⁵⁷

New Jersey regulations also require all insurance companies, health service corporations, hospital service corporations, medical service corporations, HMOs authorized to issue health benefits plans in New Jersey, and ODS’s to make network directories available to all members and prospective members containing accurate and current information on all providers.²⁵⁸ At a minimum, directories must include “name, gender, office locations, phone numbers, professional designation, specialty, acceptance of new patients, practice limitations, and languages spoken other than English” for all participating providers.²⁵⁹ They also must “contain a listing of the carrier’s in-network hospital outpatient facilities by the types of services the facilities provide.”²⁶⁰ A carrier’s electronic directory needs to include features that help users customize searches for providers, including the

has an insufficient number or type of participating providers to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the state insurance commissioner.”); CORLETTE *ET AL.*, *supra* note 216, at 1, 9.

²⁵⁴ See N.J.A.C. § 11:24A-4.6(a); N.J. DEP’T OF BANKING & INS., APPEAL AND COMPLAINT GUIDE FOR NEW JERSEY CONSUMERS, http://www.state.nj.us/dobi/division_consumers/insurance/appealcomplaintguide.pdf (last visited Aug. 21, 2014).

²⁵⁵ See N.J. DEP’T OF BANKING & INS., BULLETIN NO. 13-10: NETWORK ACCESS AND ADEQUACY - RECONSTRUCTIVE BREAST SURGERY, at 1-2 (May 3, 2013), *available at* http://www.state.nj.us/dobi/bulletins/blt13_10.pdf.

²⁵⁶ *Id.* at 2.

²⁵⁷ *Id.*

²⁵⁸ *Id.* N.J.A.C. § 11:24C-4.5(a) (managed care plans); *see also id.* §§ 11:24-9.1(d)(6) (HMOs); 11:24A-4.2(a) (HCQA as applied to carriers offering managed care plans); 11:4-37.3(b)(5) (selective contracting arrangements, including a licensed or certified ODS, HMO, or PPO).

²⁵⁹ *Id.* § 11:24C-4.5(b).

²⁶⁰ *Id.* § 11:24C-4.5(c).

capacity to search for specialties and geographic areas.²⁶¹ Within five business days of receiving a request from any member or prospective member, carriers must mail their current provider directory.²⁶²

All issuers are required to develop a system to ensure that information within provider directories is "accurate and current."²⁶³ Within twenty days of receiving confirmation from a provider or the Council for Affordable Quality Healthcare ("CAQH")²⁶⁴ that information in the directory has changed or is not accurate, carriers must update their electronic directories.²⁶⁵ The regulation establishes a process by which carriers may challenge a notice that provider information is inaccurate.²⁶⁶ It also sets forth a process to confirm the participation of a provider who has not submitted a claim within twelve months or otherwise communicated his or her intention to continue to participate in the network and for whom CAQH has not reported any change in provider status, which process includes an obligation to update the provider directory as needed.²⁶⁷

2. Federal Regulation of Network Adequacy

The ACA for the first time created federal oversight of network adequacy, although only for QHPs. Prior to its enactment, the federal government largely deferred to the state on network adequacy. The ACA opts for a broad standard and left the states with considerable flexibility to determine how to regulate QHP networks. 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."²⁶⁸ The statute also requires plans to include Essential Community Providers ("ECPs") within plan networks, where available, "that serve predominately low-income, medically-underserved individuals."²⁶⁹

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,

²⁶¹ *Id.* § 11:24C-4.5(d).

²⁶² *Id.* § 11:24C-4.5(e).

²⁶³ *Id.* § 11:24C-4.6(a).

²⁶⁴ CAQH is a nonprofit alliance of insurers and trade associations that seeks to "accelerate the transformation of business processes in healthcare through collaboration, innovation and a commitment to ensuring value across stakeholders." *About CAQH*, <http://www.caqh.org/about.php> (last visited Aug. 14, 2014).

²⁶⁵ N.J.A.C. § 11-24C-4.6(c).

²⁶⁶ *Id.*

²⁶⁷ *Id.* § 11-24C-4.6(d).

²⁶⁸ 42 U.S.C. § 18031(c)(1)(B).

²⁶⁹ *Id.* § 18031(c)(1)(C).

including [those] . . . that specialize in mental health and substance abuse services, to assure that all services will be available without unreasonable delay."²⁷⁰

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.”²⁷¹ Through guidance issued in 2013, CMS created a safe harbor for QHP applications demonstrating the participation of at least twenty 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.²⁷² QHP applicants that did not meet the safe harbor but have at least ten percent of available ECPs in the plan service area could submit a narrative justification describing how their networks provide an adequate level of service for low-income and medically underserved consumers.²⁷³ Applicants who satisfied neither the safe harbor nor the ten percent minimum expectation could submit a narrative justification describing how their current network will provide access and how they plan to increase ECP participation in the future.²⁷⁴

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.²⁷⁵ The provider directory must indicate if a provider is not accepting new patients.²⁷⁶ 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 it encouraged issuers to include information such as “languages spoken, provider credentials, and whether the provider is an Indian provider.”²⁷⁷ The agency, however, has not issued guidance regarding how frequently directories need to be updated.²⁷⁸

Neither the federal statute nor regulations define key terms, like “unreasonable delay,” instead “leaving the implementation of specific standards

²⁷⁰ 45 C.F.R. § 156.230(a)(2).

²⁷¹ *Id.* § 156.235(c); *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 majority of covered professional services through physicians employed by the issuer or through a single contracted medical group.” *Id.* §§ 156.235(a)(2) & (b).

²⁷² CMS, *2013 Letter to Issuers*, *supra* note 99, at 7.

²⁷³ *See id.*

²⁷⁴ *Id.* at 7-8.

²⁷⁵ 45 C.F.R. § 156.230(b).

²⁷⁶ *Id.*

²⁷⁷ CMS, *2013 Letter to Issuers*, *supra* note 99, 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 99, at 46.

²⁷⁸ *See* MCCARTY & FARRIS, *supra* note 231, at 2.

either to insurers or to the states.”²⁷⁹ For the 2014 plan year, “[i]n states with sufficient network adequacy reviews,” CMS is relying on state analyses and recommendations concerning network adequacy as part of the federal QHP certification evaluation process.²⁸⁰ CMS also indicated that it would monitor network adequacy by, for example, tracking complaints and gathering data from QHP issuers.²⁸¹

B. Post-ACA Network Adequacy Experiences

One of the main strategies insurers are using to keep premiums in check while complying with the ACA’s coverage and rating requirements is reconfiguring and, commonly, narrowing and, in some cases, tiering their networks.²⁸² According to a recent survey of hospital networks available on the exchanges, ninety-two percent of all people eligible to buy QHPs on the exchanges nationally could have chosen a plan with a narrow network of participating hospitals.²⁸³ Narrow hospital networks comprise forty-eight percent of all exchange plan networks in the United States and sixty percent of exchange plan networks available in the largest city in each state.²⁸⁴ Narrowed or tiered plans generally offer consumers a lower premium in exchange for a smaller network of hospitals or providers than consumers would

²⁷⁹ Nguyen, *supra* note 226, at 1; *see also* DEP’T OF HEALTH & HUMAN SERVCES., *Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, Interim Final Rule*, 77 Fed. Reg. 18310, 18419 (Mar. 27, 2012) (“We note that nothing in the final rule limits an Exchange’s ability to establish more rigorous standards for network adequacy. We also believe that this minimum standard allows sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside the Exchange and are relevant to local conditions. Finally, placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current State practice.”).

²⁸⁰ CMS, *2013 Letter to Issuers*, *supra* note 99, at 6. CMS relied on issuer accreditation in states that lacked sufficient network adequacy reviews. *See id.*

²⁸¹ *See id.*

²⁸² *See* David Blumenthal, M.D., M.P.P. & Sara R. Collins, Ph.D., *Health Coverage under the Affordable Care Act – A Progress Report*, N. Eng. J. Med, Jul. 2, 2014, at 4; Harold Brubaker, *Blue Cross offers guides to health-care ‘tiers’*, THE INQUIRER (Oct. 7, 2013), *available at* 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).

²⁸³ *See* MCKINSEY CTR., *supra* note 224, at 2 & n.6. The survey used the following definitions: “[B]road networks have more than 70 percent of all hospitals in the rating area participating, narrow networks have 31 to 70 percent of all hospitals in the rating area participating, and ultra-narrow networks have 30 percent or less of all hospitals in the rating area participating. We classified a network as tiered if the payor put different hospitals into different tiers with different co-payment requirements. . . . [W]e use the phrase narrowed network to refer to narrow, ultra-narrow, and tiered networks in the aggregate.” *Id.* at 2.

²⁸⁴ *Id.* at 2.

find in traditional networks.²⁸⁵ By limiting the doctors or hospitals available to patients, insurers hope to keep costs down.

Early news reports often criticized these narrow networks for restricting patient access to needed medical care.²⁸⁶ A survey by the Associated Press found that the nation's best cancer centers are not included in the networks for many exchange plans throughout the country.²⁸⁷ 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.²⁸⁸ There also was an outcry when Anthem Blue Cross Blue Shield -- the only issuer that applied to sell QHPs in New Hampshire this year -- left ten of twenty-six hospitals in the state out of its network.²⁸⁹

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.²⁹⁰ 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 plans' provider

²⁸⁵ 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*, at 15 (Jul. 2014), available at http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf.

²⁸⁶ See, e.g., Carrie Feibel, *Specialty Care Is A Challenge In Some ACA Plans*, KAISER HEALTH NEWS (Jul. 16, 2014); Janet Lavelle, *Finding doctors who take Covered California plans isn't easy, locals say*, THE TRIBUNE (May 29, 2014), available at <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*, THE WASH. POST (Nov. 20, 2013), available at 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.

²⁸⁷ See Chad Terhune, *Anthem Blue Cross sued again over narrow-network health plans*, LA TIMES (Aug. 19, 2014 9:38 p.m.), available at <http://www.latimes.com/business/la-fi-anthem-network-suit-20140820-story.html>; Alsono-Zaldivar, *supra* note 220. 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, as discussed in Section V(E), *infra*.

²⁸⁸ See Amy Snow Landa, *Left off many networks, Seattle Children's sues*, THE SEATTLE TIMES (Oct. 4, 2013), available at http://seattletimes.com/html/localnews/2021968776_acachildrenewsuitxml.html.

²⁸⁹ See Sarah Palermo, *Anthem's narrow network, N.H. insurance regulators criticized at hearing*, CONCORD MONITOR (Feb. 11, 2014), available at <http://www.concordmonitor.com/community/town-by-town/concord/10549003-95/anthems-narrow-network-nh-insurance-regulators-criticized-at-hearing>.

²⁹⁰ See Julie Appleby, *Lawsuit Accuses Anthem Blue Cross Of 'Fraudulent' Enrollment Practices*, KAISER HEALTH NEWS (July 9, 2014), available at <http://www.kaiserhealthnews.org/stories/2014/july/09/anthem-lawsuit-over-enrollment-practices.aspx>.

directories refused to accept their insurance.²⁹¹ 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.²⁹²

Several states are acting in response to concerns about network adequacy. According to a recent article in *Politico*, more than seventy bills have been introduced in twenty-two states seeking to clarify network adequacy requirements, although only a few states have passed legislation to date.²⁹³ 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," to see if consumers are able to access health care via the narrow networks.²⁹⁴

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.²⁹⁵ Following a series of listening sessions, Nevada authorized its insurance commissioner to begin regulating provider networks this year.²⁹⁶ 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, and requires that consumers not be 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.²⁹⁷ New Hampshire is considering how it might strengthen its existing network adequacy requirements.²⁹⁸

²⁹¹ See Daniel Chang, *Some South Florida docs decline to accept Obamacare*, MIAMI HERALD (Jul. 12, 2014).

²⁹² See Notes from Interview with New Jersey Hospital Association officials (on file with authors).

²⁹³ See Brett Norman, *Obamacare: Anger over narrow networks*, POLITICO (July 22, 2014), available at <http://www.politico.com/story/2014/07/obamacare-health-care-networks-premiums-109195.html>.

²⁹⁴ 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*"].

²⁹⁵ STATE OF WASH., OFFICE OF THE INS. COMM'R, INSURANCE COMMISSIONER MATTER NO. R 2013-22 (Apr. 25, 2014), available at <http://www.insurance.wa.gov/laws-rules/legislation-rules/recently-adopted-rules/documents/2013-22103P.pdf>; Paul Demko, *Reform Update: States debate network adequacy as insurers scramble to submit 2015 products*, MODERN HEALTHCARE (May 1, 2014), available at <http://www.modernhealthcare.com/article/20140501/NEWS/305019964> [hereinafter Demko, *Reform Update*].

²⁹⁶ See Demko, *Reform Update*, *supra* note 295.

²⁹⁷ See N.Y. State Assembly, Bill A09205, available at http://assembly.state.ny.us/leg/?default_fld=&bn=A09205&term=2013&Summary=Y&Text=Y; see also Nili S. Yolin, MINTZ LEVIN COHN FERRIS GLOVSKY AND POPEO PC, *New York enacts out-of-network transparency and coverage reform* (July 8, 2014), available at <http://www.healthlawpolicymatters.com/2014/07/08/new-york-enacts-out-of-network-transparency-and-coverage-reform/>.

²⁹⁸ See Demko, *Reform Update*, *supra* note 295.

A committee of the NAIC has been meeting regularly in 2014 to consider revisions to its model state law for network adequacy, the Managed Care Network Adequacy Model Act, which has not been modified since 1996.²⁹⁹

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 2015.³⁰⁰ 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 Section 156.230(a)(2)’s requirement of access “without unreasonable delay.”³⁰¹ 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, oncology providers, and primary care providers.³⁰² Throughout this process, CMS will “share information and analysis and coordinate with states which are conducting network adequacy reviews.”³⁰³

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.³⁰⁴ 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.³⁰⁵

The 2015 Letter to Issuers also provides specific guidance on how CMS is implementing the ACA’s ECP provisions. CMS announced that it is 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

²⁹⁹ See *id.*; NAT’L ASS’N OF INS. COMM’RS & THE CTR. FOR INS. POLICY & RESEARCH, *Network Adequacy Model Review (B) Subgroup: Regulatory Framework (B) Task Force*, available at http://www.naic.org/committees_b_rftf_namr_sg.htm (last visited July 30, 2014); Nguyen, *supra* note 226, at 2. Reportedly 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., *supra* note 253, at Appendix C, 17-25.

³⁰⁰ CMS, *2015 Letter to Issuers*, *supra* note 99, at 18.

³⁰¹ *Id.*

³⁰² *Id.*

³⁰³ *Id.*

³⁰⁴ *Id.*

³⁰⁵ *Id.*

"that at least 30 percent of available ECPs in each plan's service area participate in the provider network."³⁰⁶

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.³⁰⁷ According to recent news reports, the agency plans to propose new standards to regulate network adequacy that are similar to those used to regulate Medicare Advantage networks.³⁰⁸ Medicare Advantage plans measure network adequacy using a variety of criteria, including minimum enrollee-to-provider ratios, maximum travel times and distances to providers, and average number of enrollees within a service area, which criteria vary by type of specialty provider, health care facility, and county type.³⁰⁹

The 2015 Letter to Issuers also 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.³¹⁰ If issuers offer more than one QHP, it “should be clear to consumers which directory applies to which QHP(s).”³¹¹ Consumers also should not have “to log on, enter a policy number, or otherwise navigate an issuer's website before locating the directory.”³¹² Additionally, the directory should indicate each provider's "location, contact information, specialty, and medical group, any institutional affiliations, and whether the provider is

³⁰⁶ *Id.* 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 271. *See CMS, 2015 Letter to Issuers, supra* note 99, at 23-24.

³⁰⁷ *CMS, 2015 Letter to Issuers, supra* note 99, at 18.

³⁰⁸ Robert Pear, *To Prevent Surprise Bills, New Health Law Rules Could Widen Insurer Networks*, THE NEW YORK TIMES (Jul. 19, 2014).

³⁰⁹ *See* Nguyen, *supra* 226, at 3; *see generally* Talbot *et al.*, *supra* note 226, 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”).

³¹⁰ *See CMS, 2015 Letter to Issuers, supra* note 99, at 42.

³¹¹ *Id.*

³¹² *Id.*

accepting new patients.”³¹³ CMS also encourages issuers to include “languages spoken, provider credentials, and whether the provider is an Indian health provider.”³¹⁴

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 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.”³¹⁵ 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.³¹⁶ But as discussed above, consumers and the media have raised substantial concerns regarding the adequacy of current, mostly state-based regulation. 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.³¹⁷ 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 the purpose of the law.”³¹⁸

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.³¹⁹ The widespread use of narrow networks reportedly contributed to relatively modest premiums in 2014, sixteen percent below the Congressional Budget Office’s

³¹³ See *id.* As noted in *supra* note 277, a federal regulation requires issuers to indicate in directories that providers are not taking new patients. See 45 C.F.R. § 156.230(b).

³¹⁴ *Id.*

³¹⁵ Adams, *supra* note 299.

³¹⁶ See Joyce Frieden, *Regulators Shrug at Docs’ Network Concerns*, MEDPAGE TODAY (Aug. 11, 2014), available at <http://www.medpagetoday.com/PracticeManagement/Reimbursement/47164>.

³¹⁷ DAVID BLUMENTHAL, M.D., THE COMMONWEALTH FUND, REFLECTING ON HEALTH REFORM – NARROW NETWORKS: BOON OR BANE? (Feb. 24, 2014), available at <http://www.commonwealthfund.org/publications/blog/2014/feb/narrows-networks-boon-or-bane>.

³¹⁸ See Blumenthal & Collins, *supra* note 282, at 5.

³¹⁹ BLUMENTHAL, *supra* note 317.

predictions.³²⁰ 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 network.³²¹ A similar plan would cost nearby Georgia residents eighty-six percent more each month.³²² 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.³²³ While not all consumers were happy with the restricted network, they could choose to pay more for alternative plans with broader networks.³²⁴

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.³²⁵ As a survey of exchange plans' hospital networks conducted by the consulting firm McKinsey & Company suggests, the increased use of narrow networks has provided consumers with greater choice of network offerings.³²⁶ Nearly ninety percent of consumers had the option to purchase a plan on the exchanges that included a broad network, although broad network plans had premiums that were thirteen to seventeen percent higher than narrow network plan premiums.³²⁷ Notably, McKinsey found "no meaningful performance difference between broad and narrowed exchange networks" based on four CMS hospital quality metrics.³²⁸ 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.³²⁹ Ario believes that the ACA anticipated competition that includes plans with narrow networks among a broad range of choices.³³⁰

As is true in the debate over essential health benefits,³³¹ 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

³²⁰ Blumenthal & Collins, *supra* note 282, at 4; COLLINS *ET AL.*, *supra* note 285, at 15.

³²¹ See Jordan Rau, *In Unhealthy Eastern Tennessee, Limited Patient Options Bring Some Of The Country's Cheapest Premiums*, KAISER HEALTH NEWS (Jul. 8, 2014).

³²² See *id.*

³²³ See *id.*

³²⁴ See *id.*

³²⁵ Reed Abelson, *More Insured, but the Choices Are Narrowing*, THE NEW YORK TIMES (May 12, 2014), available at http://www.nytimes.com/2014/05/13/business/more-insured-but-the-choices-are-narrowing.html?_r=0.

³²⁶ See MCKINSEY CTR., *supra* note 224, at 2.

³²⁷ *Id.*

³²⁸ *Id.* at 3. Note, however, that academic medical centers had higher rates of participation in broad networks. See *id.*

³²⁹ COLLINS *ET AL.*, *supra* note 285, at 15.

³³⁰ See Sara Hansard, *Need for More Young Enrollees on Exchanges Highlighted at Health-Care Outlook Event*, BLOOMBERG BNA HEALTH INS. REPT. (Jan. 22, 2104) [hereinafter "Hansard, *Need for More*"].

³³¹ See Section II, *supra*.

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.’”³³²

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 recent McKinsey survey found that twenty-six 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 forty-two percent for consumers who previously were not insured.³³³ Forty percent of consumers surveyed who chose an exchange plan would have liked more information about which providers participated in their plan.³³⁴

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 eleven percent identified choice of doctors or providers as the most important factor.³³⁵ 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 much focused on buying the cheapest plans, period.”³³⁶ 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.³³⁷

³³² Norman, *supra* note 293.

³³³ See MCKINSEY CTR., *supra* note 224, at 3, 14.

³³⁴ *Id.* at 15.

³³⁵ KAISER FAMILY FOUNDATION, *Topline: Survey of Non-Group Health Insurance Enrollees*, at 19 (June 2014), available at <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.”).

³³⁶ Joanne Sammer, *ACA Exchanges: Price still king*, MANAGED HEALTHCARE EXECUTIVE (May 30, 2014), available at <http://managedhealthcareexecutive.modernmedicine.com/managed-healthcare-executive/news/aca-exchanges-price-still-king?page=full>.

³³⁷ See, e.g., Judy Sarasohn, U.S. DEPT OF HEALTH & HUMAN SERVCES., *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 Robert Mandler Jr., who initially did not plan to enroll in an exchange plan but then was glad he did because he subsequently learned he had a late-stage cancer); see generally Korobkin, *supra* note 335, at 28 (noting that “regardless how diligently a health care consumer might investigate and compare health plan options before enrolling, she 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]”).

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.³³⁸ Quality metrics can be a valuable tool to evaluate whether “less-costly providers have comparable or better quality” than more costly providers.³³⁹ 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.³⁴⁰ Further, accountable care organizations (“ACOs”), which build quality measures into their design, “with significant scale in a local market can become narrow network products.”³⁴¹ Consumers need more information to help them distinguish high-quality narrow networks from the rest.

³³⁸ Nguyen, *supra* note 226, at 4. *Accord* Andrew Bindman, *JAMA Forum: Much Ado About Narrow Networks* (Aug. 13, 2014), available at <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).

³³⁹ BLUMENTHAL, *supra* note 317; *see also* Timothy Layton, *If plans are only offering narrow networks, blame information asymmetry*, THE INCIDENTAL ECONOMIST BLOG (May 29, 2014 1:15 p.m.), available at <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), available at <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, that “performance networks” that are based on performance and not just costs “are definitely increasing in popularity”).

³⁴⁰ Joel Ario, MANATT HEALTH SOLUTIONS, *The Emerging Exchange Marketplace: A Post Op Evaluation of the Affordable Care Act Launch*, A Presentation to the Nat’l Assoc’n of Specialty Health Orgs. & the Nat’l Assoc’n of Vision Care Plans, at 25 (May 6, 2014), available at http://specialtyhealthsummit.org/yahoo_site_admin/assets/docs/Ario.127104233.pdf; *see also* Sarah Kliff, *Obamacare’s narrow networks are going to make people furious – but they might control costs*, THE WASH. POST WONKBLOG (updated Jan. 13, 2014 1:30 p.m.) (“When your choice of hospitals gets limited to those with high quality ratings then, all of a sudden, a limited network doesn't seem so bad at all. . . . It all depends on the quality of providers that end up in the narrow network, and how well they work together to deliver health care.”), available at <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/01/13/obamacares-narrow-networks-are-going-to-make-people-furious-but-they-might-control-costs/>.

³⁴¹ Ario, *supra* note 340, at 26; *see generally* *Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; Proposed Rule*, 76 Fed. Reg. 41866, 41899 (July 15, 2011) (explaining that HHS had 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”), available at <http://www.gpo.gov/fdsys/pkg/FR->

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. 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, six of 10 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.³⁴²

Similarly, in a Kaiser Family Foundation poll of non-group health insurance enrollees, forty-five percent of respondents were very satisfied and thirty-six percent were somewhat satisfied with their choice of primary care doctors available under their plan.³⁴³ Forty-three percent were very satisfied and thirty-seven percent were somewhat satisfied with their choice of hospitals, and thirty-five percent were very satisfied and another thirty-five percent were somewhat satisfied with their choice of specialists.³⁴⁴ Fifty-six percent believed that their current plan offered about the same choice of primary care doctors, thirteen percent thought it offered more choice, and twenty-seven percent thought it offered less choice than their pre-ACA coverage.³⁴⁵

Without dismissing concerns over access to particular providers, Joel Ario cautions against overreacting to narrow networks because “[t]he market really does

[2011-07-15/pdf/2011-17610.pdf](http://www.bakerdonelson.com/files/Uploads/Documents/BartrumNashvilleCouncil.pdf); see, e.g., Thomas Bartrum, Esq. & Deborah Farringer, Esq., BAKER DONELSON, *The Rise of Narrow Networks: Opportunities, Risks & Legal Uncertainties*, <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”).

³⁴² COLLINS *ET AL.*, *supra* note 285, at 2.

³⁴³ KAISER FAMILY FOUNDATION, *Topline*, *supra* note 335, at 8.

³⁴⁴ *Id.* at 9.

³⁴⁵ *Id.* at 23.

need some room to innovate here.”³⁴⁶ 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.”³⁴⁷ Regulators should also consider whether to adapt network adequacy requirements to reflect delivery system and technological innovations, including value-based purchasing, care coordination, physician-extendors, care coordinators, and telemedicine.³⁴⁸

Joel Ario has acknowledged that one area for potential regulatory inquiry is over whether insurers are adequately disclosing their plans’ narrow networks.³⁴⁹ 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.”³⁵⁰ Indeed, David Cusano has suggested that if regulators act early to improve transparency surrounding QHP provider networks, “[t]hat might mitigate the need for more prescriptive network adequacy standards going forward.”³⁵¹ 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.”³⁵² A similar tool that would enable easy comparison of QHPs by provider network also would be a helpful addition to exchange websites.

There are calls for state and federal regulators to increase their efforts to monitor plan networks and whether consumers are accessing care in- or out-of-

³⁴⁶ Paul Demko, *Flurry of new ACA rules adds to insurers’ uncertainty*, MODERN HEALTHCARE (Mar. 17, 2014), available at <http://www.modernhealthcare.com/article/20140317/NEWS/303179949>.

³⁴⁷ *Quote of the Day*, AIS’S HEALTH BUSINESS DAILY (Apr. 3, 2014), available at <http://aishealth.com/enews/businessnews/2014-04-03> (quoting Joel Ario in a gated article).

³⁴⁸ 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), https://www.ncqa.org/Portals/0/Public%20Policy/Exchanges&NetworkAdequacy_2.11.13.pdf (last visited July 31, 2014) (“We recommend that regulators and other stakeholders explore how to account for new models of care and the growing trend to address beneficiary issues via non-face-to-face encounters. It may be time to move beyond traditional, more prescriptive requirements that freeze in place old models when new models can offer better patient access, better experience and more cost effective care. Instead of relying on time and distance standards, regulators could focus more on information from patients regarding their expectations about access as well as their experience of care.”).

³⁴⁹ Hansard, *Need for More*, *supra* note 330.

³⁵⁰ Norman, *supra* note 293; see also CORLETTE ET AL., *supra* note 216, at 1, 9.

³⁵¹ Hansard, *State Regulators*, *supra* note 294; see also Layton, *supra* note 339.

³⁵² 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), available at http://www.nationalhealthcouncil.org/NHC_Files/Pdf_Files/NHCCComments-Draft2015IssuerLetter.pdf.

network.³⁵³ 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.³⁵⁴ 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.”³⁵⁵ 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.”³⁵⁶

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,³⁵⁷ 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.³⁵⁸ This information should offer valuable insights into the network adequacy of plans that should help regulators strike the right balance “among cost, quality, access, and choice.”³⁵⁹

As Sandy Praeger has observed, “[o]ne size fits all doesn’t work” in network adequacy regulation.³⁶⁰ The Sentinel Project will examine network adequacy issues in New Jersey. Like other states, New Jersey has seen an increase in tiered products.³⁶¹ Some carriers are offering plans with tiered hospitals.³⁶² One novel

³⁵³ See CORLETTE *ET AL.*, *supra* note 216, at 1.

³⁵⁴ See NAIC HEALTH INS. & MANAGED CARE (B) COMM., *supra* note 253, at 5.

³⁵⁵ *Id.*

³⁵⁶ Nguyen, *supra* note 226, at 2. In New Jersey, for example, plans file information about their networks with DOBI, which the agency reviews. But generally DOBI does not conduct detailed network analysis of plan adequacy through geomapping or similar approaches. Rather, typically complaints trigger investigations of plan network adequacy. DOBI also does not keep track of how many in-network exceptions plans are granting to help identify trends or more systemic problems. See Notes of Interviews with N.J. Dep’t of Banking & Ins. Staff (on file with authors). Cf. STATE OF MAINE, BUREAU OF INS., DEP’T OF PROF’L & FINANCIAL REGULATION, MAINE HEALTH EXCHANGE ADVISORY COMM., *Affordable Care Act and Maine’s Health Ins. Market* (Jun. 3, 2014), available at http://www.maine.gov/pfr/insurance/ACA_Index.html (summarizing Decision INS 803-2013 requiring Anthem to provide Maine Bureau of Insurance with “ongoing reports on member experience in ten southern counties, including: % of open practices for both primary care and high-volume specialists[;] r]esults of consumer surveys specifically related to ability to access care as needed[;] c]onsumer complaints related to accessing needed care[;] and r]equests for approval for out of network service”).

³⁵⁷ See Nguyen, *supra* note 226, at 5.

³⁵⁸ See 42 U.S.C. §§ 18031(e)(3)(A), 300gg-15a.

³⁵⁹ Cusano & Thomas, *supra* note 282; see also CORLETTE *ET AL.*, *supra* note 216, 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”).

³⁶⁰ Adams, *supra* note 299.

³⁶¹ See Notes of Interviews with N.J. Dep’t of Banking & Ins. Staff (on file with authors).

³⁶² See *id.*

form of tiering seeks to encourage care delivery reform by charging lower copays to incentivize patients to use patient centered medical home (“PCMH”) physician networks and higher copays to access primary care providers outside of the PCMH network.³⁶³ As detailed above, New Jersey has in place detailed network adequacy regulations. DOBI also interprets tiered networks as containing separate networks, each of which must comply with the state’s detailed network adequacy requirements.³⁶⁴ The Project will examine how well New Jersey’s existing regulatory structure is working and whether there is the need for refinement to ensure networks are adequate to permit meaningful access to appropriate care.

V. DISCRIMINATION IN HEALTH INSURANCE PLAN DESIGN AND ADMINISTRATION

A final way in which 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.³⁶⁵ Coverage exclusions and provider networks are examples of aspects of an insurance plan’s design with the potential to be discriminatory.³⁶⁶ Aspects of plan administration that can be discriminatory include eligibility determinations, coverage interpretations, medical necessity decisions, and rescissions of coverage.³⁶⁷

³⁶³ *See id.*

³⁶⁴ *See id.*; Notes of Interviews with N.J. insurance carriers (on file with authors). *Accord* NAIC HEALTH INS. & MANAGED CARE (B) COMM., *supra* note 253, at 8 (“Network adequacy determinations focus on an adequate number of network providers to address the health needs of the enrolled or prospective enrolled members. So in the case of HMOs, PPOs, POS plans and EPOs, the analysis is to ensure adequacy of those networks. When the plan includes one of those network types in a tiered network arrangement—and only if the same network providers are included—no additional network adequacy analysis should be required. If the tiered network contains different providers in each tier, then it is important that the network analysis focus on the preferred tier to ensure that there are a sufficient number of providers in the tiers to provide adequate access.”).

³⁶⁵ 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”).

³⁶⁶ *See* Sections 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).

³⁶⁷ *See* Section III, *supra* (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 in insurance can be based on criteria such as age, gender, national origin, race, or religion, as well as based on health status. Before the passage of the ACA, it was standard practice in many states for insurers to make eligibility determinations and to set premiums based on health status. 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.³⁶⁸

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.³⁶⁹ 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.”³⁷⁰

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.³⁷¹ In the 1980s, HIV disease was new and feared, and

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”).

³⁶⁸ 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).

³⁶⁹ Baker, *supra* note 368, at 1598.

³⁷⁰ 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); SEE ALSO Kate Greenwood, Rutgers Center for State Health Policy & Seton Hall Law Center for Health & Pharmaceutical Law & Policy, *The Affordable Care Act’s Risk Adjustment and Other Risk-Spreading Mechanisms: Needed Support for New Jersey’s Health Insurance Exchange 3* (AUG. 2012) (“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.”).

³⁷¹ See 4-13 THE LAW OF LIFE AND HEALTH INSURANCE § 13.06 (“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. (Sept. 30, 2013) (alleging that the coverage limit for durable medical equipment in California’s benchmark plan

people who contracted it were expensive to treat.³⁷² 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 HIV³⁷³ and by excluding HIV disease-related care from coverage.³⁷⁴ People with mental illness, genetic preconditions, and a history of injury from domestic violence similarly have been excluded from coverage.³⁷⁵

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.³⁷⁶ This does not mean that discrimination will not occur, however. This Section begins with a review of the pre-ACA federal- and state-level 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 Section 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.

“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”).

³⁷² Kenneth Vogel, *Discrimination on the Basis of HIV Infection: An Economic Analysis*, 49 OHIO ST. L.J. 965, 986 (1989) (“The average person with AIDS will incur approximately \$100,000 in medical costs over his or her remaining lifetime, and the fatality rate is quite significant. Approximately seventy-five percent of those diagnosed with AIDS before January 1983 had died by the end of August 1985. In addition, approximately twenty-five percent of those infected with HIV will contract AIDS or ARC within the first five years of infection. Such high rates of mortality and the substantial magnitude of health costs pose a problem for the private insurance industry that bears substantial portions of the risk of medical costs through health insurance, and of the risk of mortality losses through life insurance.”).

³⁷³ Ronen Avraham *et al.*, *Understanding Insurance Antidiscrimination Laws*, 87 S. CAL. L. REV. 195, 217-18 (2014) (“During the AIDS panic in the late 1980s, various life and health insurers began to refuse to insure individuals who failed HIV antibody tests. Various commentators excoriated this practice, arguing that the HIV antibody test was too unreliable to support such testing because it created an unacceptably heterogeneous population of HIV positive individuals and individuals with false positives, forcing the latter to bear the financial burden of the former.”); Vogel, *supra* note 372, at 991 (arguing that “it would be inappropriate to exclude all HIV positive individuals from coverage. While HIV seropositivity does correlate with the occurrence of AIDS, there are equivalent factors which correlate with the more frequent causes of premature death”).

³⁷⁴ Vogel, *supra* note 372, at 991 (arguing that “AIDS is not an unusually important cause of death, nor is its exclusion necessary to prevent the destruction of the insurance market. It is, therefore, inappropriate to exclude coverage for costs attributable to AIDS from either group or individual health or life insurance policies unless all of the higher risk losses are also excluded”).

³⁷⁵ Mary Crossley, *Discrimination Against the Unhealthy in Health Insurance*, 54 U. KAN. L. REV. 73, 99-107 (2005).

³⁷⁶ See discussion in Subsection V(D), *infra*.

A. The Intersection of Federal Anti-Discrimination Legislation and Health Insurance Practices prior to the Passage of the Affordable Care Act

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, which prohibits discrimination based on “race, color, or national origin” in programs or activities that receive “Federal financial assistance,”³⁷⁷ was passed, at least in part, “to put an end to ‘separate, but equal’ access to health care.”³⁷⁸ Title VI explicitly states, however, that it does not apply to insurance contracts.³⁷⁹ Similarly, Title IX of the United States Education Amendments of 1972,³⁸⁰ which prohibits sex discrimination in federally-funded educational programs and activities, and the Age Discrimination Act of 1975,³⁸¹ which prohibits age discrimination in programs or activities receiving Federal financial assistance, do not apply to contracts of insurance.³⁸²

Section 504 of the Rehabilitation Act of 1973 prohibits discrimination based on disability, but only in government-funded programs or activities.³⁸³ In addition, Section 504, at least arguably, does not apply to contracts of insurance.³⁸⁴ The Americans with Disabilities Act (“ADA”), which was passed in 1990, extends to, and prohibits, discrimination by private actors based on disabling health conditions.³⁸⁵ The ADA has a safe harbor provision, however, that states that the statute does not

³⁷⁷ 42 U.S.C. § 2000d.

³⁷⁸ Ruqaiyah 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).

³⁷⁹ 42 U.S.C. § 2000d-4 (“Nothing in this title shall add to or detract from any existing authority with respect to any program or activity under which Federal financial assistance is extended by way of a contract of insurance or guaranty.”).

³⁸⁰ 20 U.S.C. § 1681.

³⁸¹ 42 U.S.C. § 6101.

³⁸² 20 U.S.C. § 1685 (“Nothing in this title shall add to or detract from any existing authority with respect to any program or activity under which Federal financial assistance is extended by way of a contract of insurance or guaranty.”) & 42 U.S.C. § 6103(a)(4) (“Not later than ninety days after the Secretary publishes final general regulations under paragraph (a)(3), the head of each Federal department or agency which extends Federal financial assistance to any program or activity by way of grant, entitlement, loan, or contract other than a contract of insurance or guaranty, shall transmit to the Secretary and publish in the Federal Register proposed regulations to carry out the provisions of section 303 and to provide appropriate investigative, conciliation, and enforcement procedures.”).

³⁸³ 29 U.S.C. § 794.

³⁸⁴ 45 C.F.R. § 84.3(h) (“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 North 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”).

³⁸⁵ 42 U.S.C. §§ 12101-12113.

prohibit insurers “from underwriting risks, classifying risks, or administering such risks that are based on or not inconsistent with State law[.]”³⁸⁶

By contrast, Title VII of the Civil Rights Act of 1964, which prohibits discrimination in employment based on “race, color, religion, sex, or national origin,” extends to employer-provided health benefits.³⁸⁷ 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.”³⁸⁸ The Age Discrimination in Employment Act³⁸⁹ extends to employer-provided health benefits as well, but it “explicitly allows employers to provide older workers with lesser benefits than younger workers.”³⁹⁰

The Health Insurance Portability and Accountability Act (HIPAA),³⁹¹ 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,³⁹² 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.³⁹³ 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.³⁹⁴ HIPAA also restricts the ability of group health plans to exclude pre-existing conditions from coverage.³⁹⁵ 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[.]”³⁹⁶ Professor Jessica Roberts summarizes the statute as follows: “HIPAA . . . outlaws excluding or

³⁸⁶ 42 U.S.C. § 12201(c).

³⁸⁷ 42 U.S.C. §§ 2000e-2000e-17.

³⁸⁸ *Pregnancy Discrimination*, U.S. EQUAL EMP’T OPPORTUNITY COMM’N, <http://www.eeoc.gov/eeoc/publications/fs-preg.cfm> (last visited Aug. 14, 2014).

³⁸⁹ 29 U.S.C. §§ 621-34.

³⁹⁰ Crossley, *supra* note 375, at 96.

³⁹¹ Health Insurance Portability and Accountability Act, 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.).

³⁹² 42 U.S.C. § 300gg-11(a)(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.” 42 U.S.C. § 300gg-11(a)(1)(B).

³⁹³ 42 U.S.C. § 300gg-2(a).

³⁹⁴ 26 U.S.C. § 9802(a)(1)(A)-(H); 29 U.S.C. § 1182(a)(1)(A)-(H); 42 U.S.C. § 300gg-1(a)(1)(A)-(H).

³⁹⁵ 26 U.S.C. § 9801(a); 29 U.S.C. § 1181(a); 42 U.S.C. § 300gg(a) (1996).

³⁹⁶ 26 U.S.C. § 9802(b)(1); 29 U.S.C. § 1182(b)(1); 42 U.S.C. § 300gg-1(b)(1).

medically underwriting *individuals* in the context of group health insurance.”³⁹⁷ 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 small groups based on the health status of the groups’ individual members.

The Genetic Information Nondisclosure Act of 2008 (GINA)³⁹⁸ applies more broadly than HIPAA, to individual as well as to group health plans, but is more limited in its scope, banning only discrimination based on genetic information. Under GINA, health insurers cannot request, require, purchase, or use genetic information for underwriting purposes, they cannot treat genetic information as a preexisting condition, and they cannot adjust premium or contribution amounts on the basis of genetic information.³⁹⁹ 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.”⁴⁰⁰

B. New Jersey Law Addressing Discrimination in Health Insurance

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, New Jersey included, 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.”⁴⁰¹ The NAIC Model Act also prohibits “refusing to insure, refusing to continue to insure, or limiting the amount of coverage available to an individual

³⁹⁷ Roberts, *supra* note 365, at 1180.

³⁹⁸ Genetic Information Nondisclosure Act, Pub. L. No. 110-233, 122 Stat. 881 (codified in scattered sections of 26 U.S.C., 29 U.S.C., and 42 U.S.C.).

³⁹⁹ See 29 U.S.C. 1182(b)(3)(c) & (d); 42 U.S.C. § 300gg-4(b)(3)(c) & (d); 42 U.S.C. § 300gg-53(a)-(e).

⁴⁰⁰ Roberts, *supra* note 365, at 1184.

⁴⁰¹ NAT’L ASS’N OF INS. COMM’RS, *Unfair Trade Practices Act* § 4(G)(1) (Jan. 2004), available at <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), available at <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), available at <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.”⁴⁰²

Here in New Jersey, a statute bars “discriminat[ion] against any person or group of persons because of race, creed, color, national origin or ancestry of such person or group of persons in the issuance, withholding, extension or renewal of any policy of life or health insurance or annuity or in the fixing of the rates, terms or conditions therefor, or in the issuance or acceptance of any application therefor.”⁴⁰³ There is also a provision that adopts the NAIC’s language, barring:

[m]aking or permitting 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 policy or contract of accident or health insurance or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatsoever.⁴⁰⁴

Moreover, in New Jersey, the individual and small group markets have been subject to guaranteed issue and guaranteed renewal requirements for many years, preventing issuers from taking health status into account in making eligibility determinations even before the passage of the ACA.⁴⁰⁵ New Jersey also:

implemented a modified community rating system that prohibit[ed] insurers in its individual or small group markets from [charging more in premiums based] on health status but permit[ting] insurance companies in some of its markets to charge different premiums for the same coverage based on the different ages, genders, geographic locations, and family compositions of subscribers.⁴⁰⁶

⁴⁰² NAT’L ASS’N OF INS. COMM’RS, UNFAIR TRADE PRACTICES ACT § 4(G)(5), *supra* note 401.

⁴⁰³ N.J. STAT. §§ 17:29B-4 (7)(c) & 17B:30-12(a).

⁴⁰⁴ *Id.* §§ 17:29B-4 (7)(b) & 17B:30-12(d); *see also id.* § 17:29A-4 (requiring that “every insurer which makes its own rates, shall make rates that are not unreasonably high or inadequate for the safety and soundness of the insurer, and which do not unfairly discriminate between risks in this State involving essentially the same hazards”).

⁴⁰⁵ *Id.* §§ 17B:27A-6(a) (providing that an individual health benefits plan “shall guarantee coverage for an eligible person and his dependents on a modified community rated basis”) & 17B:27A-19(b) (providing that “[e]very small employer which elects to be covered under any health benefits plan who pays the premium therefor and who satisfies the participation requirements of the plan shall be issued a policy or contract by the carrier”).

⁴⁰⁶ 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 5 (Aug. 2012), *available at* <http://www.cshp.rutgers.edu/publications/evaluating-federal-and-new-jersey-regulation-of-rating-factors-and-rate-bands>.

Finally, as discussed above in Section II(A), New Jersey limited insurers' ability to use coverage exclusions to discriminate based on health status by adopting standard plans in its individual and small group markets and by passing mandates requiring that insurance plans cover treatment for particular conditions.⁴⁰⁷

New Jersey also has a generally-applicable Law Against Discrimination ("LAD"), which provides that:

[a]ll persons shall have the opportunity to obtain employment, and to obtain all the accommodations, advantages, facilities, and privileges of any place of public accommodation, publicly assisted housing accommodation, and other real property without discrimination because of race, creed, color, national origin, ancestry, age, marital status, affectional or sexual orientation, familial status, disability, nationality, sex, gender identity or expression or source of lawful income used for rental or mortgage payments, subject only to conditions and limitations applicable alike to all persons.⁴⁰⁸

While the LAD states that it should not be construed "to interfere with the operation of the terms or conditions and administration of any bona fide retirement, pension, employee benefit or insurance plan or program,"⁴⁰⁹ some have argued that this "safe harbor" provision should be read narrowly to exclude only employment-based insurance plans or programs.⁴¹⁰

In a case decided in 1998, a New Jersey federal court decided that an insurance company did not violate the LAD's prohibition on discrimination on the basis of disability when the company established a higher deductible for individuals with cystic fibrosis than for those without the disease, for two reasons. First, "the New Jersey state legislature has addressed the issue of discrimination in insurance and has expressly disallowed discrimination only between those risks involving *essentially the same hazards*."⁴¹¹ The second, and, in the court's opinion, more fundamental, reason was that "the process of evaluating and establishing insurance premiums and other means of discriminating between risks is complex and nuanced, and its oversight properly lies with the Commissioner [of DOBI], subject to the statutory requirements."⁴¹² The court concluded that if the plaintiffs

⁴⁰⁷ See Section II(A), *supra*.

⁴⁰⁸ N.J. STAT. § 10:5-4.

⁴⁰⁹ *Id.* § 10:5-2.1.

⁴¹⁰ *Yourman by & through Yourman v. People's Sec. Life Ins. Co.*, 992 F. Supp. 696, 703 (D.N.J. 1998) (stating that "logic and linguistics" support reading the safe harbor provision narrowly to exclude only employment-based insurance).

⁴¹¹ *YOURMAN*, 992 F. SUPP. AT 704 (EMPHASIS IN ORIGINAL) (CITING N.J. Stat. § 17:29A-4).

⁴¹² N.J. STAT. § 17B:30-12.

prevailed on their argument that the LAD required insurers to “treat people with cystic fibrosis or any other handicap no differently from people not similarly disabled,” it “would improperly distort the industry and the state legislated system of insurance regulation.”⁴¹³

DOBI has promulgated a number of regulations addressing health insurance discrimination. One regulation provides that applications for individual health insurance “shall not include . . . questions that: pertain to race, creed, color, national origin or ancestry of the proposed insured.”⁴¹⁴ There also is a regulation governing insurance producers that provides that “[n]o insurance producer shall refuse to take an application from a policyholder or prospective policyholder for any reason based in whole or in part upon the race, color, creed, religion, sex, marital status or physical impairments of an applicant or policyholder, or for any arbitrary, capricious, or unfairly discriminatory reason, or for any reason which is contrary to Federal or State law.”⁴¹⁵ That regulation goes on to state, however, that producers can “refus[e] to submit an application to an insurer where there exists a contractual arrangement with an insurer to perform underwriting pursuant to established and legally permissible written underwriting guidelines or acceptance criteria and the refusal is based on these guidelines or criteria.”⁴¹⁶

Even before the enactment of the ACA, then, New Jersey law provided substantial, albeit not complete, protection from discrimination in health insurance.

C. Federal and New Jersey 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), which was passed in 2008, built upon groundwork laid by earlier legislation, the Mental Health Parity Act of 1996 (MHPA).⁴¹⁷ 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.⁴¹⁸

Many states passed mental health parity laws as well. New Jersey’s mental health parity law, passed in 1999, required individual and group health insurance plans to cover “biologically-based mental illness’ under the same terms and

⁴¹³ *Yourman*, 992 F. Supp. at 704.

⁴¹⁴ N.J.A.C. § 11:4-16.7(a)(1).

⁴¹⁵ *Id.* § 11:17A-2.7.

⁴¹⁶ *Id.*

⁴¹⁷ 29 U.S.C. § 1185a & 42 U.S.C. § 300gg-26.

⁴¹⁸ *See* Sarah Goodell, *Health Policy Brief: Mental Health Parity*, HEALTH AFFAIRS 2 (Apr. 3, 2104).

conditions as provided for any other sickness under the contract.”⁴¹⁹ The statute defines “biologically-based mental illness” as:

a mental or nervous condition that is caused by a biological disorder of the brain and results in a clinically significant or psychological syndrome or pattern that substantially limits the functioning of the person with the illness, including but not limited to, schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive compulsive disorder, panic disorder and pervasive developmental disorder or autism.⁴²⁰

DOBI has explained that the phrase “same terms and conditions” prohibits applying different copayments, deductibles, or benefit limits to biologically-based mental health benefits than are applied to other medical or surgical benefits.⁴²¹ The New Jersey law was a significant step towards the goal of equal treatment for mental and physical health conditions, but it was not comprehensive as it did not cover disorders that were not recognized as being biologically-based, such as eating disorders or post-traumatic stress disorder.⁴²² The federal MHPAEA covered a broad array of mental health and substance use disorders, but it did not apply to individual and small group insurance plans.

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].”⁴²³

⁴¹⁹ L. 1999, c. 106 (codified as amended at scattered sections of N.J.S.A. §§ 17:48-1, 17:48A-1, 17:48E-1, 17B:26, 17B:27, 17B:27A-2, 17B:27A-17, and 26:2J-1).

⁴²⁰ *Id.*

⁴²¹ N.J. DEP’T OF BANKING & INS., BULLETIN NO. 01-06 (May 25, 2001), *available at* http://nj.gov/dobi/bulletins/blt01_06.htm.

⁴²² Compliance with New Jersey’s mental health parity requirements also has been a concern. In a Bulletin issued on May 25, 2001, then-Insurance Commissioner Karen L. Suter wrote: “It has recently come to the Department’s attention that some New Jersey health insurers may not be complying with the requirements of the [New Jersey mental health parity law]. The purpose of this Bulletin is to remind insurers of their obligation pursuant to the Act to provide coverage for biologically-based mental illness under the same terms and conditions as provided for any other sickness. Insurers are further reminded that this mandated benefit is required to be included in all new policy and contract forms issued after the effective date of the Act, and in endorsements to in[]force policies and contracts upon renewal.” *Id.*

⁴²³ Baker, *supra* note 368, at 1602.

D. The Patient Protection and Affordable Care Act

The ACA extended the MHPAEA to all health insurance plans in the individual market.⁴²⁴ In addition, as discussed above in Section II(B), most individual and small group health insurance plans must provide coverage of mental health and substance use disorder services as one of the ten categories of essential health benefits required by the ACA.⁴²⁵ As the Department of Labor has explained, the essential health benefits regulations require 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.”⁴²⁶

The ACA also is the first federal law to directly address and ban 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.⁴²⁷ Issuers are barred from establishing “rules for eligibility”⁴²⁸ and from charging higher premiums based on: (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.⁴²⁹

⁴²⁴ See 42 U.S.C. § 300gg-26 (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 *id.* § 18031(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”).

⁴²⁵ See Section II(B), *supra*.

⁴²⁶ *FAQs About Affordable Care Act Implementation Part V and Mental Health Parity Implementation*, U.S. DEP’T OF LABOR, <http://www.dol.gov/ebsa/faqs/faq-aca5.html#Footnotes> (last visited Aug. 15, 2014).

⁴²⁷ 42 U.S.C. § 300gg-4.

⁴²⁸ “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).

⁴²⁹ 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 RAGONE, *supra* note 406, at 6-7.

Section 1201 makes a limited exception to its prohibition on discrimination based on health status for employer-sponsored “wellness programs.”⁴³⁰ As the implementing regulations explain, the ACA does not bar “plan provisions that vary benefits (including cost-sharing mechanisms) or the premium or contribution for similarly situated individuals in connection with a wellness program.”⁴³¹ Wellness programs that are “participatory,” that is, that reward employees for satisfying conditions that are unrelated to their health status, are permissible as long as they are made available to all similarly situated individuals.⁴³² An example of a participatory wellness program provided in the regulations is “[a] program that reimburses employees for all or part of the cost for membership in a fitness center.”⁴³³ Wellness programs that are “health-contingent,” that is, “that require[] an individual to satisfy a standard related to a health factor to obtain a reward,” are more stringently regulated.⁴³⁴ Among other restrictions, the amount of the reward is capped at thirty percent of the total cost of employee-only coverage under the plan, unless the program is designed to prevent or reduce tobacco use, in which case the reward is capped at fifty percent.⁴³⁵ Programs also must offer a “reasonable alternative standard” for individuals “for whom . . . it is unreasonably difficult due to a medical condition to satisfy the otherwise applicable standard.”⁴³⁶ Wellness programs “must be reasonably designed to promote health or prevent disease.”⁴³⁷ They may not be “a subterfuge for discriminating based on a health status factor.”⁴³⁸

The regulations implementing Section 1201 generally approve of health insurer actions to the extent that they are “applied uniformly to all similarly situated individuals” and are “not directed at individual participants or beneficiaries.”⁴³⁹ 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

⁴³⁰ 42 U.S.C. § 300gg-4(j).

⁴³¹ 45 C.F.R. § 146.121(f) (noting that the wellness program exception is contained in *id.* §§ (b)(2)(ii) and (c)(3)).

⁴³² *Id.* § 146.121(f)(2).

⁴³³ *Id.* § 146.121(f)(1)(ii)(A).

⁴³⁴ *Id.* § 146.121(f)(1)(iii).

⁴³⁵ *Id.* § 146.121(f)(5).

⁴³⁶ *Id.* §§ 146.121(f)(3)(iv) & (4)(iv).

⁴³⁷ *Id.* §§ 146.121(f)(3)(iii) & (4) (iii).

⁴³⁸ 42 U.S.C. § 300gg-4(j)(3)(B).

⁴³⁹ 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).

participants or beneficiaries based on any health factor of the participants or beneficiaries.⁴⁴⁰

A second provision of the ACA, Section 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 Section 504 of the Rehabilitation Act (disability).⁴⁴¹ Unlike other anti-discrimination laws, Section 1557 explicitly states that it applies where the federal funds in question consist of “credits, subsidies, or contracts of insurance.”⁴⁴²

HHS has not yet promulgated regulations implementing Section 1557. On August 1, 2013, the agency’s office for Civil Rights (“OCR”) published a Request for Information in which it sought comments from stakeholders; comments were due on September 30, 2013.⁴⁴³ Among the questions OCR asked stakeholders to comment on was, “What are examples of the types of programs or activities that should be considered health programs or activities under Section 1557 and why?”⁴⁴⁴ Many commenters argued, as the National Health Law Program did, that “an insurance company in a Marketplace that receives federally-subsidized payments such as through premium tax credits” would be covered.⁴⁴⁵ The organization America’s Health Insurance Plans, by contrast, analyzed the question at the level of the plan, not the company.⁴⁴⁶ AHIP stated that “only individual insurance sold through the Exchange marketplaces” would even arguably be covered, noting that it “continue[s] to research the question.”⁴⁴⁷

Discrimination is also addressed in other provisions of the ACA and in their implementing regulations. The regulations governing QHP issuers provide that an “issuer must not, with respect to its QHP, discriminate on the basis of race, color,

⁴⁴⁰ *Id.* § 146.121(b)(2)(B).

⁴⁴¹ 42 U.S.C. § 18116(a).

⁴⁴² *Id.*

⁴⁴³ OFFICE OF THE SEC’Y, U.S. DEP’T OF HEALTH & HUMAN SERVS., *Request for Information Regarding Nondiscrimination in Certain Health Programs or Activities*, 78 Fed. Reg. 46,558, 46,558-46,560 (Aug. 1, 2013) [hereinafter “*Request for Information*”].

⁴⁴⁴ *Id.* at 46,559.

⁴⁴⁵ 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) [hereinafter “Spitzer Letter”].

⁴⁴⁶ Letter from Daniel T. Durham, Executive Vice President, Policy and Regulatory Affairs, and Julie Miller, Deputy General Counsel, American’s Health Insurance Plans, to Leon Rodriguez, Director, Office for Civil Rights, U.S. Dep’t of Health & Human Servs. (Sept, 30, 2013).

⁴⁴⁷ *Id.*

national origin, disability, age, sex, gender identity or sexual orientation.”⁴⁴⁸ A separate provision extends the requirement to any issuer “providing EHB.”⁴⁴⁹

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[.]”⁴⁵⁰ 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.”⁴⁵¹

The regulations implementing the EHB requirement provide 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.”⁴⁵² This general rule against discrimination is subject to the caveat that “[n]othing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.”⁴⁵³

The statute and regulations also address discriminatory marketing practices. 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 identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.⁴⁵⁴

In addition to Sections 1201 and 1557, which target discrimination on the part of insurance issuers, the ACA also includes provisions directed to regulators.

⁴⁴⁸ 45 C.F.R. § 156.200(e).

⁴⁴⁹ *Id.* § 156.125(b).

⁴⁵⁰ 42 U.S.C. § 18022(b)(4)B).

⁴⁵¹ *Id.* § 18022(b)(4)(C) & (D).

⁴⁵² 45 C.F.R. § 156.125(a).

⁴⁵³ *Id.* § 156.125 (c).

⁴⁵⁴ *Id.* § 147.104(e); *see also id.* § 156.225; 42 U.S.C. § 18031(c)(1)(A).

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E. The Continuing Possibility of Health Status Discrimination: Risk Classification by Design

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 requirements⁴⁵⁷ “eliminate the traditional authority of health insurance companies to choose whom they will insure[.]”⁴⁵⁸ Moreover, the prohibition on preexisting condition exclusions⁴⁵⁹ eliminates their authority to choose which risks they will insure against. The ACA does not, however, eliminate insurers’ incentive to attract low-risk consumers and avoid high risk (including disabled or chronically ill) consumers.

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 the issuers wish to attract, and less attractive to those they do not. Professor Baker’s term for this subtle form of discrimination is “risk classification by design.”⁴⁶⁰ 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.”⁴⁶¹

⁴⁵⁵ 42 U.S.C. § 18022(b)(4)(B).

⁴⁵⁶ *Id.* §§ 18022(b)(4)(C) & (D).

⁴⁵⁷ *Id.* § 300gg-1(a)-(b)(1) (“Subject to subsections (b) through (e), each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.”); 42 U.S.C. § 300gg-2(a) (“If a health insurance issuer offers health insurance coverage in the individual or group market, the issuer must renew or continue in force such coverage at the option of the plan sponsor or the individual, as applicable.”).

⁴⁵⁸ Baker, *supra* note 368, at 1588.

⁴⁵⁹ 42 U.S.C. § 300gg-3.

⁴⁶⁰ Baker, *supra* note 368, at 1580.

⁴⁶¹ *Id.* at 1610.

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 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.⁴⁶² First, as discussed in Section 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.”⁴⁶³ Plans must cover essential health benefits,⁴⁶⁴ subject to limits on enrollee cost-sharing.⁴⁶⁵ Plans must also meet one of the four “actuarial value” or metal level requirements, which are denoted bronze, silver, gold, and platinum.⁴⁶⁶ Professor Baker writes that “by reducing the range of variation among plans, the[se] minimum standards reduce the room for” risk classification by design.⁴⁶⁷

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.⁴⁶⁸ 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.”⁴⁶⁹

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.⁴⁷⁰

⁴⁶² *Id.* at 1611-15.

⁴⁶³ *Id.* at 1587.

⁴⁶⁴ 42 U.S.C. § 18022(a) & (b).

⁴⁶⁵ *Id.* § 18022(c).

⁴⁶⁶ *Id.* § 18022(d).

⁴⁶⁷ Baker, *supra* note 368, at 1588.

⁴⁶⁸ GREENWOOD, *supra* note 370, at ii.

⁴⁶⁹ Baker, *supra* note 368, at 1614.

⁴⁷⁰ 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), *available at*

Professor Baker argues that the medical loss ratio actually encourages insurers to enroll high-risk individuals. 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.”⁴⁷¹

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.⁴⁷² 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[.]”⁴⁷³ 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.⁴⁷⁴

In its 2015 Letter to Issuers, CMS explained its approach to ensuring “compliance with nondiscrimination standards” in FFMs, an approach which it encourages state-run exchanges to use as well.⁴⁷⁵ CMS writes:

[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.⁴⁷⁶

Among the benefits CMS expects to compare with regard to cost-sharing are inpatient hospital stays, inpatient mental/behavioral health stays, specialist visits, emergency room visits, and prescription drugs.⁴⁷⁷ The agency explains 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.”⁴⁷⁸ With regard to prescription drug coverage, the agency’s review will focus on “plans that are outliers

<http://www.cshp.rutgers.edu/publications/the-affordable-care-act-and-medical-loss-ratios-federal-and-state-methodologies>.

⁴⁷¹ Baker, *supra* note 368, at 1614.

⁴⁷² *Id.* at 1611-12.

⁴⁷³ 18 U.S.C. § 18031(e)(1).

⁴⁷⁴ Baker, *supra* note 368, at 1612.

⁴⁷⁵ *2015 Letter to Issuers*, *supra* note 99, at 27.

⁴⁷⁶ *Id.* at 28.

⁴⁷⁷ *Id.*

⁴⁷⁸ *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.”⁴⁷⁹

On May 29, 2014, The AIDS Institute, a Tampa-based non-profit, and the National Health Law Program, filed a complaint with the Office of Civil Rights of HHS 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.”⁴⁸⁰ Each of the four plans is 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.⁴⁸¹ Some enrollees also are subject to deductibles.⁴⁸² Finally, for at least three of the four plans, medications placed in the least-preferred tier are subject to prior authorization requirements and quantity limits.⁴⁸³ The complainants write that “[t]he practice of placing all anti-retrovirals on the highest tier is not a market norm or necessity.”⁴⁸⁴ In support of this argument, they point to the fact that “[o]ther issuers [of Florida QHPs] vary tiering or place HIV drugs on more affordable tiers.”⁴⁸⁵ The complainants contend 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.”⁴⁸⁶

In response to 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.⁴⁸⁷ Avalere Health focused on the out-of-pocket expense patients could face for each drug, whether branded or generic, in nineteen different drug classes.⁴⁸⁸ It found that fifty-two percent of silver plans require coinsurance of thirty

⁴⁷⁹ *Id.* at 28.

⁴⁸⁰ 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), AVAILABLE AT [HTTP://WWW.HEALTHLAW.ORG/PUBLICATIONS/BROWSE-ALL-PUBLICATIONS/HHS-HIV-COMPLAINT#.U_1BMGPP-Uk](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), AVAILABLE AT [HTTP://NEWS.YAHOO.COM/AIDS-PATIENTS-FEAR-DISCRIMINATION-ACA-EXCHANGE-212246484.HTML](http://news.yahoo.com/aids-patients-fear-discrimination-aca-exchange-212246484.html).

⁴⁸¹ Administrative Complaint, *supra* note 480, at 8-9.

⁴⁸² *Id.*

⁴⁸³ *Id.*

⁴⁸⁴ *Id.* at 10.

⁴⁸⁵ *Id.*

⁴⁸⁶ *Id.* at 3.

⁴⁸⁷ AVALERE HEALTH, AN ANALYSIS OF CERTAIN EXCHANGE PLAN BENEFITS 5 (June 2014), available at http://www.phrma.org/sites/default/files/20140521_FINAL%20PhRMA_High%20Coinsurance%20and%20Tier%20Placement_Avalere%5B7a%5D_0.pdf.

⁴⁸⁸ 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->

percent or higher for all covered drugs in at least one class, while thirty-nine percent of silver plans require coinsurance of forty percent or higher for all covered drugs in at least one class.⁴⁸⁹ Avalere Health also found that eighty-six percent of silver plans place all covered drugs in at least one class on the highest formulary tier.⁴⁹⁰

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

[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.⁴⁹¹

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.”⁴⁹² 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.”⁴⁹³

F. The Continuing Possibility of Health Status Discrimination: 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.”⁴⁹⁴ In a

[exchange-plan-benefits-for-certain-medicines#sthash.o0bB3Xh0.pdf](#) (last visited Aug. 15, 2014) [hereinafter “COVERAGE WITHOUT ACCESS”].

⁴⁸⁹ AVALERE HEALTH, *supra* note 487, at 2-3.

⁴⁹⁰ *Id.* at 4.

⁴⁹¹ PHRMA, *supra* note 488.

⁴⁹² *Id.*

⁴⁹³ KEITH ET AL., *supra* note 366, at 11.

⁴⁹⁴ 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 2006 vii (Prepared for Office of Disability, Aging & Long-Term Care

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.”⁴⁹⁵

Inequities in plan design may persist. For example, plans may continue to use different medical necessity criteria 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.⁴⁹⁶ A study of large group plans’ compliance with the MHPAEA that Goplerud conducted for HHS in November 2013, revealed that twenty percent of such plans required higher copayments, and four percent required more in coinsurance, for in-network outpatient MH/SUD services than for equivalent medical or surgical care.⁴⁹⁷ 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.”⁴⁹⁸

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.”⁴⁹⁹ 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.”⁵⁰⁰ 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

Policy, Office of the Ass’t Sec’y for Planning & Evaluation, U.S. Dep’t of Health & Human Servs. Nov. 2013), available at <http://aspe.hhs.gov/daltcp/reports/2013/mhpaeAct.shtml>.

⁴⁹⁵ Goodell, *supra* note 418, at 4.

⁴⁹⁶ 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”].

⁴⁹⁷ GOPLERUD, *supra* note 494, at xii.

⁴⁹⁸ *Id.*

⁴⁹⁹ 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), AVAILABLE AT [HTTP://WWW.AG.NY.GOV/PRESS-RELEASE/AG-SCHNEIDERMAN-ANNOUNCES-SETTLEMENT-EMBLEM-HEALTH-WRONGLY-DENYING-MENTAL-HEALTH-AND](http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-emblem-health-wrongly-denying-mental-health-and).

⁵⁰⁰ *Id.*

life-threatening condition” and “only agreed to cover the treatment after the Attorney General’s Health Care bureau intervened.”⁵⁰¹ 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 withdrawal.”⁵⁰² Notably, the Attorney General’s settlement with EmblemHealth is one of three mental health parity settlements that the New York State Attorney General reached with insurers in the first half of 2014.⁵⁰³

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.”⁵⁰⁴ 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.”⁵⁰⁵

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.⁵⁰⁶ The Treatment Research Institute found that these medications were subject to a variety of utilization management techniques including prior authorization requirements, “fail first” requirements, and limits on dosage and prescription duration.⁵⁰⁷ Not one of the commercial plans

⁵⁰¹ *Id.*

⁵⁰² *Id.*

⁵⁰³ *See id.*; Press Release, New York 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), available at <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, New York 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), available at <http://www.ag.ny.gov/press-release/ag-schneiderman-announces-settlement-health-care-insurer-wrongfully-denying-mental> (announcing settlement with Cigna Corporation).

⁵⁰⁴ Jayne O’Donnell, *Is Substance Abuse Coverage as Equal as Required?*, USA TODAY (Mar. 10, 2014).

⁵⁰⁵ *Id.*

⁵⁰⁶ MADY CHALK *ET AL.*, REPORT OF COMMERCIAL HEALTH PLAN MEDICATION COVERAGE AND BENEFITS SURVEY (TREATMENT RESEARCH INSTITUTE FOR THE AMERICAN SOC’Y OF ADDICTION MEDICINE 2013), available at <http://www.asam.org/docs/advocacy/Implications-for-Opioid-Addiction-Treatment>.

⁵⁰⁷ *Id.* at 17.

studied covered methadone maintenance therapy.⁵⁰⁸ Here in New Jersey, recommendations released this year by the Governor’s Council on Alcohol and Drug Abuse included that “GCADA should work with lawmakers, such as the members of the Senate Oversight Committee, to facilitate meaningful discussions about insurance practices that create barriers to mental health and substance abuse treatment.”⁵⁰⁹

Another potential area of dispute is whether the parity rule applies to treatments for autism. On the one hand, applied behavior analysis and other therapies often needed by children with autism could be considered “rehabilitative and habilitative services and devices,” which is one of the Act’s ten essential health benefits.⁵¹⁰ Habilitative care is, as discussed above in Section II(C), left undefined in the statute, but it is defined at HealthCare.gov as “[h]ealth care services that help you keep, learn, or improve skills and functioning for daily living,” such as “therapy for a child who isn’t walking or talking at the expected age.”⁵¹¹ On the other hand, many treatments for autism also could be considered to fall under the “mental health and substance use disorder services, including behavioral health treatment” essential health benefit.⁵¹² This dispute is of significance because if autism therapies are habilitative services, they can be subject to non-dollar limits, such as limits on the number of hours or units of service that an insurance company will cover.⁵¹³ If they are mental health services, then the MHPAEA would apply and such limits might not be permissible.

A Bulletin issued by the Connecticut Insurance Department in April of 2014 announced that health insurance plans could convert the dollar limit on “behavioral therapy” set forth in the state’s autism insurance mandate into non-dollar limits.⁵¹⁴

⁵⁰⁸ *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 496.

⁵⁰⁹ TASK FORCE ON HEROIN AND OTHER OPIATE USE BY NEW JERSEY’S YOUTH AND YOUNG ADULTS, GOVERNOR’S COUNCIL ON ALCOHOL AND DRUG ABUSE, CONFRONTING NEW JERSEY’S NEW DRUG PROBLEM: A STRATEGIC ACTION PLAN TO ADDRESS A BURGEONING HEROIN/OPIATE EPIDEMIC AMONG ADOLESCENTS AND YOUNG ADULTS 6 (2014), *available at* <http://www.state.nj.us/treasury/gcada/policy/master/>.

⁵¹⁰ 42 U.S.C. § 18022(b). *See* Section II(B), *supra*.

⁵¹¹ *Habilitative/Habilitation Services*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/habilitative-habilitation-services/> (last visited Aug. 16, 2014).

⁵¹² 42 U.S.C. § 18022(b).

⁵¹³ 45 C.F.R. § 156.115(a)(1) & (b).

⁵¹⁴ STATE OF CONN. INS. DEP’T, BULLETIN HC-96 (Apr. 22, 2014), *available at* http://www.ct.gov/cid/lib/cid/Bulletin_HC-96_Autism_Spectrum_Disorders_and_Early_Intervention.pdf. Connecticut’s autism insurance mandate defines “behavioral therapy” as:

any interactive behavioral therapies derived from evidence-based research, including, but not limited to, applied behavior analysis, cognitive behavioral therapy, or other therapies supported by empirical evidence of the effective treatment of individuals diagnosed

The Insurance Department wrote that “[b]ecause the behavioral therapy benefits are classified as habilitative benefits, they are not considered subject to mental health parity. This is consistent with HHS guidance and with the approach taken by other states.”⁵¹⁵ Professor Sara Rosenbaum, however, has opined that “[t]he parity rule seems to say you can’t play games like this.”⁵¹⁶

G. The Continuing Possibility of Health Status Discrimination: 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.”⁵¹⁷ Although he points to features in the ACA that may blunt the likelihood of this form of discrimination,⁵¹⁸ it will be important for researchers to evaluate the extent to which the statute succeeds in encouraging non-discriminatory behavior.

with an autism spectrum disorder, that are: (A) Provided to children less than fifteen years of age, and (B) provided or supervised by (i) a behavior analyst who is certified by the Behavior Analyst Certification Board, (ii) a licensed physician, or (iii) a licensed psychologist.

CONN. GEN. STAT. § 38a-514b(a)(4). For purposes of the MHPAEA, “mental health benefits” is defined as:

benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

45 C.F.R. § 146.136(a) (applying to group health insurance plans). Note that the most current version of the DSM includes Autism Spectrum Disorder. *DSM-5 Diagnostic Criteria*, AUTISM SPEAKS, <http://www.autismspeaks.org/what-autism/diagnosis/dsm-5-diagnostic-criteria> (last visited Aug. 16, 2014).

⁵¹⁵ STATE OF CONN. INS. DEPT, BULLETIN HC-96, *supra* note 514.

⁵¹⁶ MICHELLE ANDREWS, *ADVOCATES WORRY CONN. DECISION COULD UNDERMINE AUTISM COVERAGE*, Kaiser Health News (JUNE 24, 2014), [HTTP://WWW.KAISERHEALTHNEWS.ORG/STORIES/2014/JUNE/24/MICHELLE-ANDREWS-ON-AUTISM-COVERAGE-AND-CHANGES-IN-CONNECTICUT.ASPX?UTM_CAMPAIGN=KHN%3A+DAILY+HEALTH+POLICY+REPORT&UTM_SOURCE=HS_EMAIL&UTM_MEDIUM=EMAIL&UTM_CONTENT=13276519&HSENC=P2ANQTZ-8O5PEMDT6QEIEI6](http://www.kaiserhealthnews.org/Stories/2014/June/24/Michelle-Andrews-on-Autism-Coverage-and-Changes-in-Connecticut.aspx?utm_campaign=KHN%3A+DAILY+HEALTH+POLICY+REPORT&utm_source=HS_EMAIL&utm_medium=EMAIL&utm_content=13276519&HSENC=P2ANQTZ-8O5PEMDT6QEIEI6) (LAST VISITED AUG. 16, 2014).

⁵¹⁷ See *supra* notes 460-461 & accompanying text.

⁵¹⁸ See *supra* notes 462-474 & accompanying text.

CMS has announced an approach to undercover discriminatory practices by reviewing – and encouraging marketplace officials to review – the proportionality of the allocation of cost-sharing among modes of service. If examination shows that costs inequitably burden people with particular vulnerabilities, CMS will take action.⁵¹⁹ This is an important initiative; it will not, however, uncover other aspects of insurance plans that might be unfairly discriminatory.

Recent complaints have raised concerns about whether formulary design in some plans disproportionately burdens people with HIV disease or other chronic conditions.⁵²⁰ 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 benefit from attentive review of the marketplace by researchers.

Numerous regulators have a role to play in enforcing the ACA's prohibitions on discrimination. 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. State insurance departments can play a similar role for plans offered for sale outside of the exchanges.

OCR is charged with enforcing the various federal laws that prohibit discrimination in health care programs. 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.”⁵²¹ The Department of Justice (“DOJ”) coordinates the enforcement of all of the federal antidiscrimination laws by all of the executive agencies, including HHS.⁵²² DOJ can also bring suit to enforce the antidiscrimination laws.⁵²³ 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.⁵²⁴

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].”⁵²⁵ However, as OCR notes in its Request for Information “[t]hese civil rights laws may be enforced in different

⁵¹⁹ See *supra* notes 475-479 & accompanying text.

⁵²⁰ See *supra* notes 480-493 & accompanying text.

⁵²¹ Section 1557 of the Patient Protection and Affordable Care Act, Office for Civil Rights, U.S. Dep't of Health & Human Servs., <http://www.hhs.gov/ocr/civilrights/understanding/section1557/> (last visited Aug. 21, 2014).

⁵²² Executive Order 12,250 (Nov. 12, 1980), available at http://www.justice.gov/crt/about/cor/EO_12250.pdf.

⁵²³ Civil Rights Div., U.S. Dep't of Justice, <http://www.justice.gov/crt/about/> (last visited Aug. 21, 2014).

⁵²⁴ Spitzer Letter, *supra* note 445.

⁵²⁵ 42 U.S.C. § 18116.

ways.”⁵²⁶ OCR 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.”⁵²⁷ OCR asks for comments on the effectiveness of the different approaches to enforcement and for ways in which they could be strengthened.⁵²⁸

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.”⁵²⁹ 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.”⁵³⁰ The Sentinel Project is actively monitoring consumer complaints in New Jersey and will draw on what it learns in evaluating the benchmark approach.

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.”⁵³¹ 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.

The Sentinel Project will work to assess the progress of the market in striking that balance between cost and care. Key facts must be developed, including the plans’ compliance with the content rules of the ACA, determinations of medical necessity and provider availability, and the treatment of vulnerable populations in the marketplace. The Project will gather information through individual representation of consumers in coverage appeals as well as interviews and consultation with insurers, consumers, providers, community representatives, and

⁵²⁶ *Request for Information*, *supra* note 443, 78 Fed. Reg. at 46,560.

⁵²⁷ *Id.*

⁵²⁸ *Id.*

⁵²⁹ KEITH ET AL., *supra* note 366, at 16.

⁵³⁰ *Id.* at 5.

⁵³¹ *Remarks by the President and Vice President at Signing of the Health Insurance Reform Bill* (Mar. 23, 2010), available at <http://www.whitehouse.gov/the-press-office/remarks-president-and-vice-president-signing-health-insurance-reform-bill>.

regulators. It will also review the literature that emerges on plans' market behavior as the ACA's implementation progresses.

The goal of the Sentinel Project is to provide a feedback loop of information directly relevant to the assessment of plans in the individual and small group markets in New Jersey. The Project's information and analysis will assist consumers as they shop for coverage; enable insurers to adjust glitches that occur as they produce and administer plans for the individual and small group markets; assist community groups as they perform public education and navigation services; and inform federal and state regulators as they review plans' current compliance and undertake their review of the regulatory underpinnings of the new and evolving world of ACA implementation.